Psychotherapy as mutual encounter: a study of therapeutic conditions

This item was submitted to Loughborough University’s Institutional Repository by the/an author.

Additional Information:

- A Doctoral Thesis. Submitted in partial fulfillment of the requirements for the award of Doctor of Philosophy of Loughborough University.

Metadata Record: [https://dspace.lboro.ac.uk/2134/6627](https://dspace.lboro.ac.uk/2134/6627)

Publisher: © David Murphy

Please cite the published version.
This item was submitted to Loughborough’s Institutional Repository (https://dspace.lboro.ac.uk/) by the author and is made available under the following Creative Commons Licence conditions.

For the full text of this licence, please go to:
http://creativecommons.org/licenses/by-nc-nd/2.5/
Psychotherapy as mutual encounter: A study of therapeutic conditions.

by

David Murphy

A Doctoral Thesis
Submitted in partial fulfillment of the requirements for the award of Doctor of Philosophy of Loughborough University

March 2010

© by David Murphy 2010
Acknowledgements

There are many people to thank and who have made this study possible. First, my thanks go to all the participants, both therapists and clients who were willing to take part in this study and without who the whole project would never have been possible.

Professor Duncan Cramer who I have known for thirty four years and who supervised this study. The breadth and depth of his knowledge and experience has been an invaluable source of guidance and an inspiration. It also acted as a reminder of how much I’ve yet to learn. Thanks must also go to my friend and colleague Professor Stephen Joseph, who in recent years has acted as sounding board, coach, and mentor in my development both personal and professional. Thanks to my father, Terry Murphy, for reading an earlier draft of the thesis and providing invaluable feedback. Most of all, this is for Lisa, whose love and commitment enabled me to have the time and energy to complete this project. Without that support, I would never have got this far, my love always. Thanks also to Ellie, Megan and Joseph my three beautiful children to who this is dedicated.
Abstract

Rogers’ (1957; 1959) claim that the client’s minimal perception of therapist empathy, unconditional positive regard and congruence as necessary and sufficient for constructive personality change has been supported equivocally. This necessary and sufficient hypothesis implies the therapeutic relationship is unilaterally therapist created via the provision of a set of specific therapeutic attitudes and delivered to the client. Recent research from the psychotherapy literature has pointed towards the role of reciprocal positive interaction between client and therapist. However, despite the common view of the therapeutic relationship as unilateral, Rogers (1959) referred to the reciprocal nature of the therapeutic conditions, therefore, suggesting the therapeutic relationship is a bidirectional process. The current study explores the mutual and reciprocal experiencing of the therapeutic conditions, their development over the early stages of the therapeutic relationship and subsequent association with an objective measure of outcome. The study analysed data relating to the quality of the mutual affective therapeutic environment from sixty two bona fide counselling/psychotherapy dyads in a naturalistic longitudinal design.

Levels of the therapeutic conditions as provided and perceived by both clients and therapists were assessed using a shortened version of the B-L RI after the first and third session and clients also completed the CORE-OM at the first and third session. The results showed that the psychotherapy was generally effective and that client’s views of the quality of the therapeutic relationship were a better predictor of outcome than therapists. Test of the effect of mutual experiencing of the therapeutic conditions were carried out using hierarchical linear multiple regression. The results showed a significant interaction between client and therapist views of the quality of the therapeutic
relationship at session three with outcome at session three. This suggested that the association between the client view of the relationship and outcome was stronger when both clients and therapists rated mutually high levels of the therapeutic relationship conditions provided by the therapist. This result was also present when considering the mutual levels of the therapeutic conditions that client and therapist perceived in the other.

These findings suggest that the perception of mutually high levels of the therapeutic conditions is able to predict outcome and supports the view that the mutual and reciprocal affective environment is associated with positive therapeutic change. The implications for practice are that clients must be considered as the central change agent in their own therapy. In effect, the study has shown that it is the client’s own feelings towards the therapist and their interaction with how the therapist feels towards the client that is an important factor in predicting outcome. It would seem that even when clients have experienced significant psychological distress, the client’s organismic striving for relationship remains and the extent this is perceived and received by the therapist is related to a positive outcome for the client. As a result of this, psychotherapy practitioners could benefit their clients by considering themselves as part of a bi-directional relational dyad. Further research is required as a result of the current findings and suggests the need to explore the nature, form and experience of mutuality within the therapeutic relationship.
## Contents

CONTENTS ........................................................................................................................ 5

PART 1 ............................................................................................................................... 9

PSYCHOTHERAPY RESEARCH: HISTORICAL OVERVIEW AND CONTEXTS.............. 9

CHAPTER 1 ........................................................................................................................ 9

INTRODUCTION ................................................................................................................ 9

1.1 GENERAL INTRODUCTION............................................................................................ 10

CHAPTER 2 ...................................................................................................................... 14

LITERATURE REVIEW 1. .............................................................................................. 14

THE OUTCOME OF COUNSELLING AND PSYCHOTHERAPY .................................. 15

2.1 SOME GENERAL DEFINITIONS OF TERMS..................................................................... 15

2.2 THE GENERAL EFFECTIVENESS OF PSYCHOTHERAPY ............................................. 16

2.2.1 Meta-analyses and comparisons with no treatment controls ...................................... 17

2.2.2 Comparisons between active therapies ..................................................................... 18

2.2.3 Comparisons between specific diagnostic categories ................................................. 21

2.2.4 Summary .................................................................................................................. 22

2.3 THE CASE FOR CONTINUING PSYCHOTHERAPY OUTCOME RESEARCH ................. 22

2.3.1 Common Factors as active ingredients ................................................................... 26

CHAPTER 3 ...................................................................................................................... 29

LITERATURE REVIEW 2 ................................................................................................. 29

THE THERAPEUTIC RELATIONSHIP ............................................................................ 29

3.1 CONCEPTUALISING THE THERAPEUTIC RELATIONSHIP ......................................... 30

3.1.1 Background and brief history...................................................................................... 30

3.1.2 Freudian perspective .................................................................................................. 31

3.1.3 The therapeutic alliance .............................................................................................. 32

3.1.4 Rogersian perspective ................................................................................................. 33

3.2 ROGERS' NECESSARY AND SUFFICIENT THERAPEUTIC RELATIONSHIP CONDITIONS .................................................................................................................... 35

3.2.1 Measuring the therapeutic relationship conditions ....................................................... 35

3.2.2 The therapeutic relationship and outcome .................................................................. 45

3.2.3 Assessing individual therapeutic conditions ............................................................... 53

3.2.4 Conceptualising empathy ............................................................................................ 54

3.2.5 Conceptualising Unconditional positive regard .......................................................... 59

3.2.6 Conceptualizing Congruence ...................................................................................... 64

3.2.7 Summary .................................................................................................................. 67

PART 2: LITERATURE REVIEW 3 ................................................................................. 68

ADDRESSING THE RESEARCH QUESTION .............................................................. 68

CHAPTER 4 ...................................................................................................................... 68

THE CASE FOR A RELATIONAL APPROACH4.1 RELATIONAL APPROACHES TO UNDERSTANDING PSYCHOLOGICAL DISTRESS ........................................................................... 68

4.1 RELATIONAL APPROACHES TO UNDERSTANDING PSYCHOLOGICAL DISTRESS ................................................................................................................... 69
CHAPTER 5 ......................................................................................................................... 90
LITERATURE REVIEW 4 ................................................................................................. 90
THE CASE FOR MUTUALITY ......................................................................................... 90

5.1 THE CASE FOR THE BI-DIRECTIONAL APPROACH ............................................... 91
5.1.1 Limitation in the current relationship research. ...................................................... 91
5.2 INTRODUCING THE CONSTRUCT OF MUTUALITY ............................................. 93
5.2.1 Conceptualising mutuality in relational psychotherapy ........................................ 93
5.3 MUTUALITY AND THE BUBER – ROGERS DIALOGUE ........................................ 96
5.3.1 The principle of mutuality the person centred approach ....................................... 96
5.3.2 Is mutuality within psychotherapy achievable? ..................................................... 99
5.4. MUTUALITY AND THE BI-DIRECTIONAL NATURE OF THE THERAPEUTIC CONDITIONS ........................................................................................................... 105
5.4.1 Introduction to empathy as a bi-directional and mutual construct ......................... 105
5.4.2 Empathy: evidence for bidirectional process ......................................................... 110
5.4.3. Unconditional positive regard: evidence for bidirectional process ...................... 121
5.4.4 Congruence: evidence for bidirectional process ..................................................... 128
5.4.5 The ‘real’ relationship ............................................................................................. 132
5.4.6 Summary: the therapeutic relationship as a bi-directional process ....................... 139
5.5 MUTUALITY AND THE ASSOCIATION WITH WELL BEING THROUGH CLOSE PERSONAL RELATIONSHIPS 
AND SOCIAL SUPPORT .................................................................................................. 142
5.5.1 Mutuality in close personal relationships ................................................................. 142
5.5.2 Summary .................................................................................................................. 148
5.6 SETTING THE RESEARCH QUESTION AND SUMMARY OF AIMS FOR THE PRESENT STUDY ................................................................. 148

PART 3: METHOD AND RESULTS ............................................................................ 151

CHAPTER 6 .................................................................................................................... 151
METHOD ....................................................................................................................... 151

6.1 DESIGN ...................................................................................................................... 152
6.2 ETHICAL CONSIDERATIONS .................................................................................. 153
6.2.1 Informed Consent ................................................................................................. 153
6.2.2 Confidentiality ..................................................................................................... 154
6.2.3 Clinical Governance ............................................................................................ 155
6.2.4 Debriefing ........................................................................................................... 156
6.3 PARTICIPANTS .......................................................................................................... 156
6.3.1 Client participants attending first session ............................................................. 157
6.3.2 Therapist participants ......................................................................................... 159
6.4 MEASURES .............................................................................................................. 160
6.4.1 Clinical Outcome in Routine Evaluation Measure (CORE-OM) .......................... 161
6.4.2 Level of distress ................................................................................................ 161
6.4.3 Clinical and Reliable Change .............................................................................. 163
6.4.4 Barrett-Lennard Relationship Inventory (B-LRI) ................................................ 167
6.5 PROCEDURE .......................................................................................................... 173
6.5.1 Recruitment of participating services ................................................................. 174
6.5.2 Recruitment of client participants ..................................................................... 177
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>THE EFFECTIVENESS OF PSYCHOTHERAPY</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td>RESULTS</td>
<td>184</td>
</tr>
<tr>
<td>8</td>
<td>ASSESSING THE QUALITY OF THE THERAPEUTIC RELATIONSHIP</td>
<td>212</td>
</tr>
<tr>
<td></td>
<td>RESULTS</td>
<td>212</td>
</tr>
<tr>
<td>9</td>
<td>AN ITEM FACTOR ANALYSIS OF A SHORTENED BARRETT-LENNARD RELATIONSHIP INVENTORY</td>
<td>196</td>
</tr>
<tr>
<td></td>
<td>RESULTS</td>
<td>196</td>
</tr>
<tr>
<td>10</td>
<td>MUTUALITY AND OUTCOME</td>
<td>237</td>
</tr>
<tr>
<td></td>
<td>RESULTS</td>
<td>237</td>
</tr>
</tbody>
</table>

6.5.3 Data collection points ............................................................................................................................. 177

10.1 INTRODUCTION TO MODERATION ANALYSES ....................................................................................................... 238
10.1.1 Moderator effects for Therapist MO on the association between Client OS and Session 3 CORE-OM ....................................................................................................................... 239
10.1.2 Moderator effect for Therapist OS on the association between Client OS and Session 3 CORE-OM ........................................................................................................................................ 241
10.1.3 Summary .................................................................................................................................................................................................................................................................................................................................. 242

CHAPTER 11 ................................................................................................................................................................................................. 243
DISCUSSION ................................................................................................................................................................................................. 243
EFFECTIVENESS OF PSYCHOTHERAPY ................................................................................................................................................................................................. 243
11.1 EFFECTIVENESS OF PSYCHOTHERAPY ................................................................................................................................................................................................. 244
11.1.1 Reliable and clinically significant improvement .................................................................................................................................................................................................................................................................. 245
11.1.2 Degree of client change – effect size .................................................................................................................................................................................................................................................................. 247
11.1.3 Deterioration ................................................................................................................................................................................................................................................................................. 248
11.1.4 Effects of different therapeutic approaches .................................................................................................................................................................................................................................................................. 249
11.1.5 Specific or non-specific effects .................................................................................................................................................................................................................................................................... 251
11.2 THE BARRETT–LENNARD RELATIONSHIP INVENTORY ................................................................................................................................................................................................. 252
11.2.1 General discussion for factor analyses of RI ................................................................................................................................................................................................................................................................ 252
11.3 THERAPEUTIC RELATIONSHIP ................................................................................................................................................................................................. 255
11.3.1 Quality of relationship experienced by clients ................................................................................................................................................................................................................................................................ 255
11.3.2 Quality of relationship experienced by therapists ................................................................................................................................................................................................................................................................ 256
11.3.3 Association between the relationship and outcome using CORE-OM ................................................................................................................................................................................................................................................................ 258
11.3.4 Summary ................................................................................................................................................................................................................................................................................................. 260

CHAPTER 12 ................................................................................................................................................................................................. 261
DISCUSSION ................................................................................................................................................................................................. 261
MUTUALITY AND OUTCOME ................................................................................................................................................................................................. 261
12.1 MUTUALITY AND OUTCOME ................................................................................................................................................................................................. 262
12.1.1 Mutuality of perceived therapist provided conditions ................................................................................................................................................................................................................................................................ 263
12.1.2 Mutuality of perceived therapist and client provided conditions ................................................................................................................................................................................................................................................................ 267
12.1.3 Implications for practice ................................................................................................................................................................................................................................................................................. 269
12.2 REFLECTION ON CONDUCTING THE STUDY ................................................................................................................................................................................................................................................................. 272
12.3 LIMITATIONS OF THE PRESENT STUDY ................................................................................................................................................................................................................................................................. 275
12.4 SUGGESTIONS FOR FUTURE RESEARCH ................................................................................................................................................................................................................................................................ 277
12.5 CONCLUSION ................................................................................................................................................................................................................................................................................................. 278

REFERENCES ................................................................................................................................................................................................................................................................................................. 280
APPENDIX 1 ................................................................................................................................................................................................................................................................................................. 315
RELATIONSHIP INVENTORY: FORMS MO AND OS ................................................................................................................................................................................................................................................................ 315
APPENDIX 2 ................................................................................................................................................................................................................................................................................................. 320
CLIENT INFORMATION AND CONSENT FORM ................................................................................................................................................................................................................................................................ 320
Part 1

Psychotherapy research: Historical overview and contexts

Chapter 1

Introduction
1.1 General introduction
The relational approach has been a major development within the psychotherapy field in recent years. Relational approaches have as their focus the effects that client and therapist have on one another within the psychotherapy relationship. However, much of the interpretation of Rogers (1957/59) theory of therapy rests upon the notion that it is the extent to which the client perceives the therapist as genuine, unconditionally accepting and empathically understanding. Despite this, little is understood of the factors that may influence this within the therapeutic relationship. The role of the client in relational approaches is central to understanding the therapeutic process. However, more recently research and theory have developed along the lines of understanding the therapeutic process as more dialogical – that client and therapist tend to affect one another. The focus of this study is the therapeutic relationship and is an exploration of the mutual and reciprocal effects of the therapeutic conditions of empathy, unconditional positive regard and congruence. In doing this, a bi-directional view is taken of these conditions is proposed.

The review of the literature begins by looking at the effectiveness of psychotherapy in Chapter 2. This is necessary as there remains heated discussion about superiority in effectiveness across the range of different therapeutic approaches currently available. However, it can be argued that in recent years, despite significant investment in trying to prove the superiority of therapeutic approaches aligned to the view that specific components are the responsible client change agents, broad equivalence in outcome remains the overarching finding. The equivalence in outcome paradox is perhaps the most contentious issue in psychotherapy research and it stands to discredit the
dominant paradigm. The alternative to a model of specificity is the common factors view and this is also briefly reviewed. The common factors view is a necessary area to consider as it acts as the bridge to the factor most associated with outcome and the factor of primary interest to this study; the therapeutic relationship. The therapeutic relationship has been one of the most systematically researched concepts within the psychotherapy research literature. It continues to hold the attention of academics, researchers and practitioners as an issue of significant import. In recent times there has been a resurgence of interest in the therapeutic relationship with many of the major schools of psychotherapy having incorporated a relational stance within their approach. The relational schools can now be found in psychoanalysis, transactional analysis and even the cognitive behavioural approach recently turning towards and recognising the therapeutic relationship as a significant factor in successful therapeutic outcome (Leahy, 2008). These recent entries to the relational family are of course in addition to the range of humanistic/existential and perhaps more centrally the person-centred and process experiential approaches to psychotherapy (Elliott and Greenberg, 2002).

Chapter three goes on to review that portion of the literature focussed on the therapeutic conditions suggested by Rogers (1957) as necessary and sufficient. This literature has repeatedly shown a consistent positive association between the therapeutic relationship conditions and psychotherapy outcome. However, this research has yielded only a relatively low to moderate association between the therapeutic relationship and outcome. This leaves those approaches, such as person-centred therapy that rely on the notion that it is the quality of the therapeutic relationship that brings about positive change, in a weakened position. This is often the argument used to suggest that the therapeutic relationship on its own is not sufficient to bring about therapeutic change. In concluding chapter three the argument is put forward that this finding may partly be a
result of the fact that most studies that have explored the association between Rogers’ therapeutic conditions and outcome have based their understanding of the therapeutic relationship as a unilateral phenomenon.

The unilateral conceptualisation is proposed as a major limitation in the research carried out so far in this field. Chapter four begins by introducing a range of theoretical perspectives that each point towards relationships as bi-directional constructs. It is shown here that a significant amount of the psychological distress people experience is aetiologicaly relational. The suggestion that psychological distress is relational, whether inter or intrapersonal, builds the case for a bi-directional understanding of the association between the therapeutic relationship construct and outcome. This view is not entirely new however, it has not to date been applied directly to the therapeutic relationship conditions. Doing so can help to shift the focus of understanding intra psychological distress as developing and being maintained through dysfunctional interpersonal relations.

The final section of the literature review draws on a range of studies that have gone some way to support this view. However, it is noted from the literature that whilst many person-centred researchers have hinted at a bi-directional formulation of the therapeutic relationship no research exists that has directly tested this hypothesis. Drawing on research from the related construct of the therapeutic alliance, it can be suggested that the therapeutic bond between client and therapist is a mutual construct. This then acts as the final step in making the case for a mutual and reciprocal experiencing of the therapeutic conditions a logical and necessary focus for study.
In the famous dialogue between Rogers and Buber, Rogers made a number of references to the terms mutuality and reciprocity. These were with regards to the therapeutic relationship and specifically in relation to how the therapeutic conditions are experienced. Mutuality and reciprocity have been the focus of psychotherapy research for some time and are central features to relational approaches. These include those grounded in interpersonal psychotherapy (Sullivan, 1953; Weissman, Markowitz & Klerman, 2000), relational psychoanalysis (Aron, 1996; Mitchell, 2000), relational-cultural therapy (Jordan, 1998), and person-centred therapy (Rogers, 1959; Schmid, 2002). The latter having more recently developed these ideas through the concept of meeting at relational depth (Mearns, 1996; Cooper and Mearns, 2005; Knox and Cooper, 2009).

This study provides a much closer focus on the mutual and reciprocal effect that client and therapist have on one another and the impact this has on outcome. Prior to this, within the field of relational psychotherapy there has been little empirical attempt to assess the mutual experiencing of Rogers’ therapeutic conditions. Indeed, within the person-centred literature there has been no known prior attempt to empirically explore the mutual and reciprocal experiencing of the therapeutic conditions and to see whether these are related to outcome. To do this the study considers mutuality in two ways. The first assesses the extent clients and therapists mutually perceive the therapist as providing the therapeutic conditions. The second assesses the extent that the client and therapist mutually experience each other as providing the therapeutic conditions. Each of these perspectives is then related to outcome to test whether mutuality is associated with therapeutic change.
Chapter 2

Literature review 1.

The outcome of counselling and psychotherapy
2.1 Some general definitions of terms
The present study is concerned with both the process and outcome of psychotherapy. Later sections of the literature review cover the process elements of the study. However, before considering these it is necessary briefly to review the literature relevant to the general effectiveness of psychotherapy. Before even this is possible, however, it will be helpful to define the terms used in this study. There is currently a division within the field of what constitutes counselling and psychotherapy and whether or not there is any meaningful difference between the two. For some, the debate is meaningless yet for others it remains a significantly contentious issue. The person-centred approach, for example, despite using both counselling and psychotherapy terms, does not differentiate with regards to the activity. This is mainly because Rogers, the founder of person-centred therapy, developed the approach as a challenge and reaction to the dominance of analytic and behavioural psychology.

On the other hand, briefer forms of psychotherapy such as Cognitive Behaviour Therapy claim to be psychotherapy but do not often engage in the longer term open ended work that person-centred psychotherapists may do. To add complexity, psychoanalysis distinguishes between analysis in its traditional form and those variants of such often referred to as psychodynamic. Within the psychodynamic field some will defer to and use the title psychotherapist and others counsellor. From all of this, it is clear before even entering into the area of integrative approaches that there is a potential minefield.

As much of the theoretical underpinning of the current study has been derived from the person-centred approach the assumption here is not to differentiate between the terms
counseling and psychotherapy. In support of this, the participant therapists are representative of all those mentioned above and refer to their title as either counsellor or psychotherapist yet work alongside one another providing essentially the same function to their clients. Indeed, in this study at times the terms may be used interchangeably, and whilst not always, will strive to best reflect the terms used by those original researchers referred to in the literature. Not more so because these researchers themselves will often include comparisons of what some may refer to as psychotherapy with counselling. In addition to this, it is possible that the generic term ‘therapy’ may be used to denote the activity derived from the interaction between therapist and client. The term therapist will be used to refer to the person who is in the role of professional helper. In most research studies this is the person delivering the intervention to the patient or client.

2.2 The general effectiveness of psychotherapy
As this study aims to look at process factors and relate these to psychotherapy outcome it is necessary to take a brief historical look at how the outcome literature has developed to the point of suggesting that psychotherapy is an effective activity. It is now broadly accepted within the field that psychotherapy is an effective method for helping people who experience many of the problems and distress commonly encountered within human living. This claim can be made with confidence and is supported by a significant body of evidence collated over a half a century or more. The mass production of outcome research was precipitated by a statement made in the 1950’s by the famous psychologist Hans Eysenck. Eysenck (1952) provocatively claimed that psychotherapy was no more effective than placebo control. Since then thousands, perhaps tens of
thousands, of studies have been carried out and have demonstrated the general effectiveness of psychotherapy.

The total corpus of literature concerning psychotherapy outcome has become so large it is now too sizeable to review in any one study. Fortunately, however, a number of researchers have used meta-analytical methods to review the reported outcome thus making a brief review of this portion of the literature more manageable. Some important findings from these studies are worth considering here.

2.2.1 Meta-analyses and comparisons with no treatment controls
Smith and Glass (1977) carried out one of the first meta-analytical studies that looked at the findings produced from early psychotherapy outcome studies. A meta-analysis was carried out on a large number of reported findings and included over four hundred psychotherapy outcome studies. The findings showed that overall, those clients receiving psychotherapy were generally better off than those who were assigned to a control group or received no treatment. However, whilst overall therapy appeared to be effective, and certainly better than receiving no treatment, interestingly differences in effectiveness between the various active therapeutic approaches being compared were found but were found to be artifacts of the outcome measure used.

Following this finding, a later meta-analysis by Smith, Glass and Miller (1980), that included those studies used in the Smith and Glass (1977) study, increased the total number of studies to four hundred and seventy five. The findings showed an average effect size of 0.85 (Cohen’s $d$; Rosenthal (1991)). This finding suggested that the
average client who received therapy improved and was better off than about 80% of control group clients. This is a moderate to large effect size and suggests there are significant benefits to receiving psychotherapy compared to not receiving psychotherapy. The results from this meta-analysis lend support to the hypothesis that psychotherapy is effective for helping to alleviate psychological distress.

A third early meta-analysis that focused on the general effectiveness of psychotherapy was carried out by Shapiro and Shapiro (1982). This study included one hundred and forty three outcome studies. The reported results confirmed the two previous findings and suggested strong support for the effectiveness of psychotherapy with a large effect size of 1.03 (Cohen's $d$; Rosenthal (1991)).

The findings from these early meta-analyses provided a robust response to the criticisms made by Eysenck (1952) and have been used as evidence to support the argument in favour of the general effectiveness of psychotherapy. However, whilst these studies demonstrate the overall effectiveness of psychotherapy, the findings did not show whether any one of the various active approaches to psychotherapy was significantly more effective than all the others. This finding proved to act as yet further stimulus for research within the field of psychotherapy outcome.

### 2.2.2 Comparisons between active therapies

Rosenzweig (1936) first claimed that the effective properties of psychotherapy could be attributed to general and common factors and that these factors would probably be found within each of the diverse range of therapeutic approaches available. Following this, albeit some significant time later, Luborsky et al (1975) noted the general
equivalence across different therapies and coined the phrase the “Dodo bird verdict.” This clever use of the reference taken from the C. S. Lewis story *Alice in Wonderland* refers to when the dodo bird claims that ‘everyone has won and all must have prizes.’

However, more recently Luborsky et al (2002) have suggested that caution is required when interpreting the findings from meta-analyses. For example, Luborsky et al (2002) note that misleading results can arise when the method of meta-analysis relies on the comparison between the effect size of an active therapy with a no treatment control group. The large study by Smith, Glass and Miller (1980) is an example where active therapies were compared with no treatment controls yet no effect sizes were reported for the comparisons between the various active therapies. Averaging effect sizes, Luborsky et al (2002) suggest, can create an impression that all treatments are equal. Therefore, it is important to not only compare the differences between each treatment and the control group, but also to test for the significance in the differences between treatments themselves.

A small number of meta-analyses comparing active therapies with each other have been identified by Luborsky et al (2002). Berman, Miller and Massman (1985) reviewed twenty studies and found a small non significant effect (Cohen’s $d$ 0.06) between cognitive therapy and desensitization. Robinson, Berman and Neimeyer (1990) reported on six meta-analyses including four with positive findings which suggested that behaviour therapy is less effective than cognitive behavioural therapy (-.24), cognitive behavioural therapy was more effective than a generic talking therapy (.37), cognitive therapy was more effective than generic talking therapy (.47) and behaviour therapy is more effective than generic talking therapy (.27). Svartberg & Stiles (1991) found a significant difference between dynamic and cognitive behaviour therapy (-.47). Three further
studies (Crits-Christoph, 1997; Luborsky, Diguer, Luborsky, Singer, & Dickter, 1993; Luborsky, Diguer, Seligman, Rosenthal et al, 1999) were included in the review by Lubrosky et al (2002) which showed no significant differences between the active therapies.

In summary, Luborsky et al (2002) compared the effects of 17 meta-analyses and found a mean uncorrected effect size using Cohen’s $d$ of 0.20. After the effect sizes from eleven studies were corrected to control for the effects of researcher allegiance a corrected mean effect size 0.14 was produced which was not significant and thus supports the original dodo bird verdict. It should be noted that each of these studies compared active therapies that were cognitive, behavioural, and cognitive-behavioural or a variation of (psycho) dynamic psychotherapy.

Humanistic therapies were not included in these results. This is unfortunate. The meta-analytic data set compiled by Elliott, Greenberg and Lietaer (2004) and later updated by Elliott and Friere (2008) is one of the largest of its kind to look at the effectiveness of experiential psychotherapy including client-centred therapy. The Elliott and Friere (2008) study has showed that pre-post effect sizes in one hundred and twenty seven studies of humanistically oriented psychotherapy remained high at a mean of 0.86 SD. This finding incorporates controlling for the weighting effects of sample size and provides a strong argument for the effectiveness of these approaches. In addition to this, the review found humanistically oriented psychotherapy was also at least equivalent to cognitive and behavioural approaches in a range of contexts and settings.
2.2.3 Comparisons between specific diagnostic categories
In considering the potential for a relational model of distress it is necessary to contemplate whether relational therapies would only do better where the problems are considered to be associated with interpersonal relations. However, this suggestion is contrary to many schools, such as those from humanistic oriented therapies and leans towards a medical model of distress. That is, specific treatments can and are designed to alleviate distress in specific problem areas. As a result of the increasing tendency towards specificity, more recent meta-analytic studies have focused on and addressed questions regarding the effectiveness of psychotherapy for specific diagnostic categories such as anxiety or depression (Lambert & Ogles 2004). Lambert and Ogles (2004) recorded that nineteen meta-analyses of psychotherapy for depression had been carried out over an eighteen year period between the Quality Assurance Project (1983) and Leichsenring (2001). Despite Leichsenring's (2001) relatively moderate effect size of 0.8 and with effect sizes reaching as high as 2.15 (Dobson 1989), these studies showed a remarkably consistent positive finding in favour of the effectiveness of psychotherapy for depression.

Meta-analyses for anxiety related disorders were also reviewed by Lambert and Ogles (2004) and whilst they state that the studies cover a far wider range of psychological problems than the reviews that looked at depressive disorders, the results again remain in favour of the effectiveness of psychotherapy for anxiety related problems compared to wait list and no treatment control comparisons. Finally, Lambert and Ogles (2004) reviewed a further fifty eight meta-analyses for a range of specific therapeutic methods for specific problems and for comparing group and individual approaches for specific diagnoses. Their final conclusion was that whilst “widely ranging rationale and
implementation, psychological interventions for various disorders consistently produce
significant outcomes when compared to various control groups” (p. 143).

2.2.4 Summary
It appears there is strong evidence to suggest psychotherapy is effective for a wide
range of emotional, psychological and relational problems. This also appears to be the
case for a number of empirically supported therapies including, behavioural, cognitive,
cognitive behavioural, psychodynamic and experiential therapies. Elliott, Greenberg and
Lietaer (2004) have stated that they were surprised and impressed by the ‘robustness of
client-centred therapy’ and that ‘time and time again, non-experiential therapy
researchers have been surprised by the long-term effectiveness of CC (client-centred)
and nondirective-supportive therapies, even when these were intended as control
groups’ (Elliott, Greenberg & Lietaer 2004; p.529).

From this it is reasonable to assume that relational approaches are at least as effective
as some non-relationally focussed therapies. Despite this, it is non-relationally focussed
therapies that currently dominate the therapeutic landscape. There are a number of
reasons why this is the case some of which are outlined below.

2.3 The case for continuing psychotherapy outcome research
Taking the above into account, it could be argued enough psychotherapy outcome
research has been carried out and there is little point in continuing the pursuit of
demonstrating effectiveness. The politics of psychotherapy research though suggest
something different. For example, in both the UK and US some therapeutic approaches
receive state approval and this in turn has shaped the therapeutic landscape considerably. For many practitioners and researchers from within the relational approaches this has meant a serious decline in the visibility, and therefore availability, of person-centred and experiential therapy, psychodynamic psychotherapy and a range of other approaches that place the relationship at the centre of practice. In trying to understand this and for the purpose of making the case for further research into the therapeutic relationship it is worth considering briefly the factors that have contributed to this.

The meta-analysis of randomised controlled trials (RCT), themselves involving comparative and or dismantling techniques, have come to be viewed as the highest form of evidence. The findings of these studies and single RCT studies have become the strongest determinant for a therapeutic approach receiving support and validation from the National Institute for Clinical Excellence (NICE). These studies have been influential both in the UK and the USA in determining evidence based therapies and empirically supported treatments respectively.

However, this approach to developing a robust evidence based field of psychotherapy has received criticism. Some might say that such a (over) reliance on this methodology has lead to the support of ‘Not Credential Trademarked Therapies’ (Rosen & Davison; 2003). Additionally, there has been a call for a reduction in the use of RCT as a method for attempting to prove one approach as having a superior effectiveness over another. Based on the apparent equivalence of all modalities, Messer and Wampold (2002) have suggested that there no longer exists a case for funding such research. Messer and Wampold (2002) have suggested findings that indicate a difference in effect, that is with one approach to psychotherapy seeming to have a greater effect than another, is
attributable to contextual factors such as the individual therapist, therapist allegiance to
an approach or the therapeutic relationship (Messer & Wampold 2002; Wampold (2001).

Cooper (2009), on the hand, has suggested it is important not to oversimplify the
complexity of the effects of psychotherapy by simply stating that all therapies are equal
for all people. However, there have been two relatively large studies that once again
indicate broad equivalence. One an RCT comparing non-directive client-centred therapy
with CBT for depression (King et al; 2000) and another comparing the effects of client-
centred therapy, CBT and psychodynamic therapy observed from routine practice (Stiles
et al; 2006). Despite this some state the need for a more nuanced analysis. For
example, Chambless (2002) makes a similar point to what Cooper (2009) has
suggested. That is, the equivalence in findings does not accurately capture the point. For
example, some people may respond better to certain types of therapy and that some
types of therapy may be better for more specific forms of anxiety (e.g. panic disorder).

Taking this point, it may be possible that some people will respond better to a non-
directive therapy that is relational. However, under the current scheme these clients do
not have the same level of access to relational therapy as they do for directive CBT
based therapy. This point is an important one. And at a time when the availability of state
funded NHS therapy depends heavily on the endorsement of organisations such as
NICE this becomes an even more crucial issue.

It seems then that equivalence in effectiveness across therapies can be attributed to one
or a number of possible suggestions. For example, it could be argued that some people
respond better to specific types of therapy, however, the randomisation within the design
of the King et al (2000) study should account for individual difference as the causal
variable. Alternatively, equivalence could be attributed to difficulties in measurement when using meta-analysis; however, this seems to have been answered by Luborsky et al (2002). Finally, this leads to the suggestion that it is common factors spanning across all psychotherapies that hold the active ingredients. Such factors are, by virtue of their name, considered to be non-specific and common across all therapeutic approaches. This means that common factors are contributing toward change and will be present, to a greater or lesser extent, whatever the presenting problem or whoever the client or therapist is. The degree to which common factors are present can vary as a function of the people involved. The relational context is influenced by the two people that make up the therapeutic dyad. This notion is particularly challenging for those who have a significant investment in any one theoretical approach, especially perhaps for those with an interest in the dominant models. Whilst it has generally been accepted that psychotherapy is effective, the proportion of effectiveness and how it works are questions that remain controversial (Castonguay & Beutler 2006).

One thing that can be taken from the above is there are two domains inhabited by researchers. The first domain is in the support of the specificity hypothesis whose aim is to identify the specific techniques that make therapy effective. The other domain is occupied by those who support the non-specific hypothesis and argues that factors common to all therapies are responsible for producing change. To explore this notion further a very brief outline review of common factors is required that will help identify the contribution to outcome made by the various process variables thought to be common across approaches.
2.3.1 Common Factors as active ingredients

Following a recent and comprehensive summing up of the psychotherapy outcome literature, Cooper (2009) has suggested the facts are friendly. Cooper’s (2009) review covers a wide range of evidence and is suggests that a significant contribution to successful psychotherapy outcome is attributable to common factors. Common factors include those dimensions of the therapeutic setting that are not specific to any particular approach or technique. They include, for example, the therapist, therapeutic model and client (Lambert & Ogles 2004). Common factors are by their nature drawn from a wide and varied source of the psychotherapy contexts and are thus present to some degree in all therapeutic approaches. However, there has been a reluctance to acknowledge their full potential, perhaps because as Frank (1976) suggested there is little to gain from showing the specific techniques that have been learned through great investment have little impact on the final analysis of therapy outcomes.

Early common factors research has shown that a range of therapeutic variables contribute to outcome (Lilley, Cramer & Murphy, 1984). Lambert and Ogles (2004) list three broad areas of common factors including thirty two separate factors. The first area includes those defined as support factors and are, amongst others, catharsis, reassurance, alliance, warmth, respect, empathy, acceptance and genuineness. The second are learning factors and some examples are giving advice, assimilating problematic experiences, feedback, insight and exploration. Third are action factors and examples may include mastery, behavioural regulation, reality testing and working through.

For common factors to be considered as legitimate agents in producing change, it is necessary to show their effects across a range of different therapeutic models. To be
sure of their contribution the effects need to be shown to be present in those models where some particular factors may not be expected to feature in an association with positive outcome. Such an example can be found in a study by Castonguay, Goldfried Wiser, Raue and Hayes (1996) which has shown that emotional processing, typically associated with experiential therapy, was related to outcome in cognitive therapy for depression. In addition to this, an argument can be made that early changes observed in clients receiving a therapeutic approach where specific techniques or interventions are thought to be the active ingredients may be attributed to common factors. Ilardi and Cragihead (1994) convincingly argued that early changes in cognitive behavioural therapy for depression, that is, change that occurred in the first four weeks of treatment, must be the result of common factors as the specific techniques of the therapeutic method had not by then been implemented. However, in response to this Tang and DeRubeis (1999) argued that in the cognitive behavioural therapies reviewed by Ilardi and Craighead (1994) clients received two sessions per week in the initial phase of treatment suggesting that there was ample opportunity for clients to be exposed to the specific elements of the therapy and it was these not the common factors that can be assumed to have lead to the changes experienced by clients.

The common factors debate is itself a significant debate in its own right and the literature extends beyond a full review in this study. However, it is important to note of all the common factors that have been subjected to research the one factor that has received the most attention is the therapeutic relationship. The therapeutic relationship is a key common factor that is viewed as relevant by all approaches to therapy and has consistently been associated with outcome across each of the major therapeutic approaches. The model for specificity is grounded in the view that it is the specific elements of a therapeutic approach that are classed as the active ingredient. This is
based on the model of understanding psychological distress as the result of specific causes. In contrast, the alternative view holds that the effective elements of psychotherapy are common factors and therefore the causes of distress are likely to be multiple and non specific. Out of this, there are a number of reasons as to why the therapeutic relationship is thought to make a significant contribution towards positive psychotherapy outcome. Outlined in more detail below is one such argument which considers the view that psychological distress itself is the result of the interpersonal and relational context which precipitates entry to psychotherapy.
Chapter 3

Literature review 2

The therapeutic relationship
3.1 Conceptualising the therapeutic relationship
Before moving on to look more closely at mutuality and reciprocity per se it is necessary to explore the therapeutic relationship more generally. As is suggested above contextual factors contribute significantly toward bringing about change in psychotherapy. This includes the possibility that distress is caused by dysfunctional interpersonal relations. In line with the view that psychological distress is aetiologically relational it stands that, when psychotherapy is effective, the therapeutic relationship will be consistently associated with positive outcomes. The therapeutic relationship, however, is not a straight forward construct and the sections below review the evidence and literature most relevant to this study. First, the evidence outlining each approach to understanding the therapeutic relationship is considered and the corresponding constituent parts of the therapeutic relationship are outlined. Following this, a brief review of the therapeutic relationship and its association with outcome is provided. Next, a more in depth look at the therapeutic relationship from a person-centred perspective is considered and will review the therapeutic conditions set out by Rogers (1957) as necessary and sufficient. Finally, the literature is used to challenge the view of the therapeutic relationship as a uni-lateral phenomenon and in so doing an exploration of the research that has adopted a bi-lateral approach will be reviewed before the concept of mutuality is introduced.

3.1.1 Background and brief history
Arguably, the therapeutic relationship is the most researched aspect within the psychotherapy literature. This body of literature is expansive and covers a wide range of therapeutic modalities. As a result the relationship between therapist and client has,
perhaps confusingly, been variously labelled *therapeutic relationship, helping relationship, working alliance, helping alliance* or *therapeutic alliance* (McCabe & Priebe, 2004). However, this confusing list of terms can be more appropriately considered as an indication of the many constituent parts of the therapeutic relationship. Below, the main elements of the therapeutic relationship are outlined and are linked to their theoretical bases.

### 3.1.2 Freudian perspective

The various conceptualizations of the relationship are largely theory driven and each typically relates to one of the main therapeutic approaches to psychotherapy. It could be suggested that there are two main categories into which conceptualisations of the therapeutic relationship fall. That is to say, they are based on either Freudian or Rogerian principles. For example, Freud’s theory of psychoanalysis and its various psychodynamic derivatives have led to a conceptualisation of the therapeutic relationship as consisting of layers of reality. Within the psychoanalytic approach there are two main components and thus constructs the therapeutic relationship as a dialectic. That is, a tension is created between the transference-countertransference layer and the real or personal relationship layer (Freud, 1919; 1937). At the transference-countertransference level, the client projects unwanted parts of the self onto the therapist by transferring feelings from other relationships onto the therapeutic relationship. In so doing, a transference relationship is constructed and the therapist then offers the client interpretations based on this layer of the relationship. The therapist’s emotional reactions to the transference are referred to as countertransference.
In conceptualising the therapeutic relationship in this way, it is only the therapist who is able to offer the client the insight to their unconscious process through the management of the countertransference. Thus, the relationship is inherently asymmetrical. The asymmetry of the therapeutic relationship within analysis is designed and created by the therapist’s tendency towards maintaining neutrality. In turn this neutrality supposedly affords the client the opportunity to express unconscious, distorted or denied aspects of the self. The therapist is then thought to help the client by making interpretations about the client’s transference with the view to making these unconscious elements of the self conscious thus leading to greater integration within the self.

The concept of the real/personal relationship is one that was recognised by Freud (1919) but is rarely mentioned in the analytic literature. However, there has been a resurgence of interest in the concept and as such much of the literature has relevance for the current study. As a result, a more detailed review of this construct is presented below.

3.1.3 The therapeutic alliance
The therapeutic alliance (Bordin, 1979) has become a term that has often been used synonymously and interchangeably with the therapeutic relationship. This is an unfortunate circumstance as the alliance actually refers only to that portion of the therapeutic relationship which is concerned with the collaboration over the goals of therapy, agreement about how best to achieve those goals and of the emotional bond between therapist and client (Bordin, 1979). The therapeutic alliance also emerged from psychoanalytic theory and is viewed as being based on elements of both the
transference-countertransference and real relationship (Greenson, 1967); however, despite the obvious psychodynamic basis of the construct, the extensive literature that has evolved from the field of alliance research has shown the concept to exert a significant influence on outcome across most if not all therapeutic approaches. This has resulted in some suggestion of the therapeutic alliance as having pan theoretical appeal (Martin, Garske & Davis 2000; Waddington, 2002). Whilst it is necessary to recognise the overlapping yet distinct components of the therapeutic relationship a full review of the alliance is neither necessary nor possible in the space provided. However, there are some studies from the part of the alliance known as the therapeutic bond that have direct relevance to the present study and therefore these will be reviewed in more detail in the sections below.

3.1.4 Rogerian perspective
The third major conceptualization, and perhaps farthest reaching of all contributions to the therapeutic relationship literature, was proposed by Rogers (1957; 1959). Rogers (1957; 1959) theoretical proposition suggested that the presence of six conditions were necessary and sufficient for therapeutic personality change to occur. Rogers' hypothesis states that when these six conditions are present they create a relational environment in which therapeutic change takes place. The theory clearly states that no other conditions are necessary. In relation to the Freudian view, Rogers recognised the phenomenon of transference, however, he disagreed with the psychoanalysts that this ought to be the central focus of the therapeutic work between therapist and client.
In contrast to this, the notion from psychoanalysis of the ‘real relationship’ (Greenson, 1967; Gelso and Hayes 1998) appears to have a significant overlap with the Rogerian conceptualization of the therapeutic relationship. That is, where the real relationship in psychoanalysis the focus is on the genuine relationship between client and therapist, this something that Rogers’ theory stated was the main objective for person-centred therapists.

It is not necessary to further develop the arguments of transference and countertransference. However, this literature can be followed up by the interested reader (Gelso & Hayes, 2002; Gelso, Kivlinghan, Wine, Jones & Friedman 1997; Greenson, 1967; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes 1996). Likewise, extensive research into the concept of the therapeutic alliance has been carried out over the last four decades and reviews of such can be found elsewhere (Cooper, 2009; Horvath & Bedi, 2002; Martin, Garske & Davis, 2000; Waddington, 2002). However, the component of the therapeutic alliance known as the therapeutic bond offers one area of overlap and is of significant interest to the present study. For example, the client and therapist components that make up the therapeutic bond are similar, but not identical, to the Rogerian therapeutic conditions. Likewise, this applies to the notion of the real relationship; therefore, this literature is relevant and will be reviewed in more detail below.

Having highlighted the various ways in which the therapeutic relationship can be conceptualised attention now turns to a more in-depth consideration of a number of key constructs. These will include the therapeutic relationship as set out by Rogers (1957; 1959). In addition to outlining the theoretical concepts, the review will consider the association between the therapeutic relationship and outcome. Following from this the
view of the therapeutic relationship as a bi-directional construct will be considered incorporating research looking at the exchange of relational conditions between client and therapist.

3.2 Rogers' necessary and sufficient therapeutic relationship conditions
The present study aims to assess the mutuality and reciprocity of the therapeutic conditions set out by Rogers' (1957; 1959) in seminal papers detailing the basic principles for client-centred therapy. In these papers Rogers identifies six conditions which he claimed to be both necessary and sufficient for constructive personality change to occur. The six conditions identified by Rogers (1959) are as follows:

1. That two persons are in contact.
2. That the first person, whom we shall term the client, is in a state of incongruence, being vulnerable, or anxious.
3. That the second person, whom we shall term the therapist, is congruent in the relationship.
4. That the therapist is experiencing unconditional positive regard toward the client.
5. That the therapist is experiencing an empathic understanding of the client's internal frame of reference.
6. That the client perceives, at least to a minimal degree, conditions 4 and 5, the unconditional positive regard of the therapist for him, and the empathic understanding of the therapist.

(Rogers, 1959; p. 213 italics original)
Prior to considering the therapeutic conditions within a bi-lateral frame, the following sections review the relevant literature concerning the development of the therapeutic conditions, their measurement and their association with outcome. Three of these six conditions have been termed the therapist conditions; empathy, unconditional positive regard and congruence and have been researched extensively over the last fifty years. This has included their application not only in psychotherapy but also in education and other helping professions (see Cornelius-White et al, 2004 and Cornelius-White, 2007 for review of contribution to education). Within the field of psychotherapy research the therapeutic conditions have been studied with a range of different client groups from mild levels of distress to those with severe psychosis (Rogers et al, 1967). Whilst it has been generally accepted that the three therapist conditions are related to successful psychotherapy outcome a number of issues remain equivocal.

For instance, not all agree with the original Rogerian hypothesis of the relationship conditions as necessary and sufficient and some suggest holding to a one size fits all method is monolithic (Norcross 2002). Indeed, with the wealth of psychotherapy research literature showing effects from a range of psychotherapy processes it is hard to imagine that the theory can account for all constructive personality change. This has led some researchers to suggest that the therapeutic relationship conditions may be necessary but not sufficient (Goldfried, 2007; Goldfried and Davila, 2005; Hill, 2007; Watson, 2007). For some, however, an even stronger rejection of Rogers hypothesis is held. For those who disagree with greater fervour, it is both the necessity and the sufficiency of the therapeutic conditions that have been questioned (Hill, 2007).

Counter to the hypothesis of the necessary and sufficient conditions the main argument suggests the use of therapeutic technique leads to better outcomes than does the
relationship alone. This argument returns to the difference between the common or specific factors debate mentioned earlier. Specific therapeutic techniques claim to work by directly correcting emotional, cognitive and behavioural aspects of client distress. The model of specificity suggests that techniques lead to greater client change than if therapists rely on the clients own resources within the therapeutic relationship.

Despite the argument in favour for the effects of specific techniques (Tang & DeRubeis, 1999; 2005) others have suggested their contribution to outcome is much less than can be accounted for by the quality of the therapeutic relationship. For example, some have suggested that specific therapeutic technique accounts for about fifteen per cent of the variance in outcome, yet approximately twice this (30% of the variance in client change) can be accounted for by the quality of therapeutic relationship. A further forty per cent by extra therapeutic factors or client variables as they are otherwise known and the remaining fifteen per cent is attributable to therapeutic expectancies/placebo (Asay and Lambert 1997).

It should be noted that Rogers (1959) himself considered the possibility that the conditions for therapeutic change may not be necessary and sufficient. Rogers (1959) referred to the findings of a study suggesting it was possible that clients commence therapy with different needs. In quoting a study by Kirtner (1955) Rogers (1959) stated that those clients who view their distress as involving interpersonal relationships and who see themselves as contributing to this in some way and who start therapy motivated to change this, are likely to do well in client-centred therapy. In addition Rogers then notes that if clients do not see they have any involvement in their difficulties for which they are attending therapy and that the problem is entirely external to them then they are much less likely to succeed in client-centred therapy and that they may require different
conditions (Rogers, 1959; pp. 214). The study by Kirtner (1955) to which Rogers refers was concerned with an association between the successfulness of client-centred therapy and individual personality variables. What is interesting here is that Rogers indicates it is the client’s perception of the nature of their problem and their self efficacy to act on this that may be the strongest determinant of therapeutic success, not that client-centred therapy is unable to help people with all sorts of different problems.

It should be noted that this view is no different to that held by many of the major schools of psychotherapy. For instance, psychological mindedness and an ability to think creatively and metaphorically have been associated as a requirement for psychoanalytic work. The same can be said of the cognitive behavioural school which requires clients, such as those seeking help for anxiety related problems, to learn and accept the cognitive model of activating stimulus, behaviour and consequence (ABC).

However, we must consider the fact that Rogers’ original theory was primarily based on a unitary concept of the self. The notion of self plurality creates the prospect that some aspects of the self may be more motivated and able to accept responsibility for change than others. The plurality of self could be applied to Kirtner’s (1955) findings. For example, if one considers the potential for a plural self for a moment it is possible that parts of the person might be more ready to change than might others. If it is these more motivated or ‘ready to change’ parts with which therapy is engaged then successful outcome is quite likely.

Any consideration of the necessary and sufficient hypothesis needs to be grounded within and take account of the theoretical model that one has an allegiance. Zuroff and Blatt (2006) make the point that four basic positions exist in relation to the therapeutic
relationship. The first is that the therapeutic relationship is not sufficient and has little or no direct effect on outcome but is necessary for the effective use of specific techniques. This view relates most closely to cognitive behavioural approaches. The second view is that the relationship itself is the only requirement for successful psychotherapy and is akin to that set out above and the Rogerian hypothesis. Third, is the view that the relationship is an essential and causal agent in therapeutic change but that it only works insofar as it relies upon specific techniques such as interpreting the transference and is clearly related to the psychodynamic perspective discussed above. Fourth is a sceptical view of the relationship in that a positive relationship is not necessary for constructive personality change to occur. As we have seen from the theoretical perspectives outlined above the relational context is a critical factor in the development of psychological distress. For this reason, it is likely that option four can be ruled out. The question though remains as to the extent that the therapeutic relationship can contribute towards change. What can be taken from the arguments presented thus far is that the therapeutic relationship is a key element in a relational approach to psychotherapy.

3.2.1 Measuring the therapeutic relationship conditions
In order to assess the association between the therapeutic relationship and outcome it is necessary to be able to measure these variables. The present study is concerned with measuring the levels of the therapeutic conditions proposed by Rogers (1957; 1959) and how they are experienced between the therapist and client. The conceptual complexity in identifying the active ingredients of psychotherapy has to some extent been mirrored in attempts to operationalize and measure therapeutic relationship variables. Early methods for measuring the therapeutic conditions used independent observer ratings of
the levels of therapeutic conditions provided by therapists and were used in the Wisconsin Schizophrenia Project (Rogers et al 1967). Truax (1966) developed a self congruence scale. This measure was also developed in order to use independent observer’s ratings of the therapeutic conditions. These early attempts at measuring the relationship variables were motivated by Truax’s (1966) belief that clients were unable to accurately perceive the therapeutic conditions. That is, observers are more able to identify the therapeutic conditions as they are present within the relationship. This view, whilst theoretically inconsistent with Rogers’ theory may have some validity. However, it was soon rejected in favour of either using therapist ratings or clients’ views of the relationship conditions.

Rogers (1957; 1959) theory clearly states that it is the extent to which the client perceives the therapeutic conditions that will determine outcome. Truax (1966) on the other hand has argued that due to client distortion and denial it is possible that perception may not be accurate. Indeed this is a similar view to that mentioned in the introductory section and was expressed by Laing, Phillipson and Lee (1966). It is possible that inaccuracies in client perception of the therapeutic conditions may go some way to explaining the mixed findings from studies that have looked at the association between relationship conditions and outcome. For example, in clients experiencing high levels of distortion, as in the case of more distressed clients such as those in the Wisconsin Project (Rogers et al, 1967), the likelihood of misperception of the therapeutic conditions is increased.

In defence, it should perhaps be noted that in referring to perception, Rogers’ definition demands that the client only needs to perceive the therapeutic conditions to a ‘minimal’ degree. Whereas Rogers concentrates on the client perception of the therapeutic
conditions, Truax on the other hand appears to be referring to the accurate symbolisation of the therapist provided conditions. This difference is important as the self experience of the organism may be that the therapist is unconditionally accepting, however, this experience may be distorted in order to fit with the self concept. For example, ‘this feels good on one hand but people are only nice to me when they want something’. This may then have an effect on how the client reports the quality of the relationship despite having had a minimal experience of unconditional positive regard.

By far the most widely used measure and the one most theoretically congruent with the person-centred view on the relationship conditions is the Barrett-Lennard Relationship Inventory (B-L RI; Barrett-Lennard, 1962). Shortly after the B-L RI was first developed by Barrett-Lennard (1962) it was later revised making several adjustments to the measure (Barrett-Lennard, 1964). Principally these revisions involved a reduction in the number of subscales from five to four, giving each subscale an equal number of items and making the wording less ambiguous on a number of items. Perhaps importantly the revising of the measure clarified the theoretical definition of the unconditionality subscales (Barrett-Lennard, 1978).

3.2.1.1 Properties and factor structure of B-L RI
The full version of the B-L RI has sixty four items with sixteen items on each of the four subscales of; empathy, level of regard, congruence and unconditionality of regard. The test re-test alpha reliabilities derived from a total of 36 pairs of students who completed the measure having based their responses on a close personal relationship were high and ranged from 0.84 to 0.90 (Barrett-Lennard, 2002).
The B-L RI is further supported by a review of published studies covering a range of therapeutic contexts and considered fifteen separate population samples (Gurman, 1977). The mean internal reliability coefficients were again very satisfactory with regard .91, empathy .84, unconditionality .74 and congruence .88. Test-retest reliability also showed stable results with mean test-retest correlations of empathy, .83, regard, .83, unconditionality of regard, .80, congruence, .85 (Gurman 1977). Barrett-Lennard (1978) has suggested that based on the consistency of the findings of high intercorrelation between the four subscales, the RI has a very high technical reliability. However, high correlation between the subscales may be indicating that the measure is assessing a single relationship factor (Cramer, 1986). To establish the RI as comprising four distinct factors the appropriate test is a factor analysis.

Four known published studies specifically looking at the factor structure of the B-L RI have been carried out to date. In large part they lend support in favour of the four factor structure originally proposed by Barrett-Lennard (1964) for the B-L RI. Walker and Little (1969) carried out a factor analysis with one hundred and fifty students who based responses on a close relationship and identified three factors similar to the empathy, regard and unconditionality scales. Lietaer (1974) created an extended one hundred and twenty three item version of the RI and administered the measure to eight hundred Dutch students based on their relationship with a parent, finding general support for the four factors. Cramer (1986a; 1986b) has carried out two factor analyses the first using the original sixty nine item B-L RI with college students and later with three hundred and thirty five university and college students based on the relationship with their closest personal friend. Both these studies found support for the four factor structure and the latter had a number of high loading items that also loaded highly on the same four
factors in the Lietaer (1974) and Walker and Little (1969) studies. From these results it would appear that the B-L RI is a reliable four factor measure.

3.2.1.2 B-L RI, rating perspectives and other relationship measures
The B-L RI is a versatile measurement tool that can be completed from a range of perspectives including client, therapist or independent observer having been used in a large number of process-outcome studies. Gurman (1977) reported that the correlations between client, therapist and independent observer perspectives were variable and ranged from .00 to .88 with a mean of .28. Specifically in regard to measures of empathy, Bohart, Elliott, Greenberg & Watson (2002) suggest it is not surprising that the correlations are generally weak when consideration is given to the complexity of the constructs involved and that client and therapist may be assessing different elements of the empathic process.

The therapeutic bond component of the therapeutic alliance has some degree of overlap with the B-L RI as both are concerned, in part, with the affective and cognitive connection between therapist and client. For example, the Vanderbilt Psychotherapy Process Scale (VPPS; Suh, Strupp & O’Malley, 1986) has eight factors one of which is termed warmth and friendliness and the items for which approximate positive regard (Farber & Lane, 2002). A recent study reported on data collected in National Institute for Mental Health Treatment of Depression Collaborative Research Programme used both a modified version of the VTAS (Krupnick et al, 1994) and the B-L RI (Zuroff & Blatt, 2006). In this study the alliance and B-L RI correlated only at low level ($r = .17, p < 0.05$) supporting the view that the alliance and therapeutic relationship conditions suggested
by Rogers are distinct from one another yet probably overlap to some degree (Zuroff and Blatt, 2006). As there was a significant positive correlation between the two measures it is reasonable to consider that as the RI may be overlapping with the bond component of the alliance. No available data was reported for the correlations between the different components of the alliance measure and those of the B-L RI. As a result it was not possible to consider the extent of the specific associations between the bond subscale and the four factors of the B-L RI.

Further support for the association between the alliance construct and the therapeutic relationship assessed using the B-L RI was found in another study. In this study researchers carried out a multiple regression test for the mediating effect of the alliance for client ratings of the RI on outcome. Watson & Geller (2005) found that the client’s session nine B-L RI scores significantly predicted session twelve alliance scores ($p < 0.01$). The alliance measure used in this study was from the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) which covers the three alliance constructs including the therapeutic bond. However, once again the data for the distinct subscales and the associations across measures were not reported.

The sections above suggest that the B-L RI is a reliable measure of the therapeutic conditions suggested by Rogers (1957) as necessary and sufficient. In addition to this, it appears that the RI is correlated with measures of the alliance and it was hypothesised from the literature reviewed so far that this may be with the bond component of the alliance. The next section looks at the association of the therapeutic relationship with outcome.
3.2.2 The therapeutic relationship and outcome
Research focusing on the association between the therapeutic relationship and outcome has tended to use either a global assessment of the therapeutic relationship or a measure of one or more of the various components of empathy, unconditional positive regard and congruence that make up the therapeutic relationship. The next section of this part of the literature review will look at those studies that have used a global assessment method and its association with outcome will be considered. There is a large body of literature and it is not possible to review the evidence in its entirety. As a result, the most relevant studies are taken from a cross section of the different areas that relationship research has been carried out. These include studies from clinical trials, non experimental trials and the emerging field of research from acute psychiatric settings. These studies are divided in this way as many clinical trials do not include patients that are deemed too severe for inclusion to the trial. As a result trial data is often seen as only being able to account for those patients most likely to improve. Reviewing data from studies of acute settings will enable inferences to be made about a broader spectrum of populations in receipt of psychotherapy.

3.2.2.1 Therapeutic relationship in clinical trials
A positive association between the therapeutic relationship and outcome has recently been found in a range of client groups including adult out-patient services for depression (Zuroff & Blatt 2006), treatment studies for depression (Watson & Geller, 2005; Watson, Gordon, Stermac, Kalogerakos & Steckley, 2003), youth and family therapy (Karver, Handelsman, Fields & Bickman, 2006), severe psychosis (Rogers et al, 1967) and schizophrenia (Hewitt & Coffey, 2005), and in general counselling (Archer, Forbes, Metcalfe & Winter, 2000).
The National Institute for Mental Health (NIMH) Treatment for Depression Collaborative Research Program (TDCRP) project (Elkin et al 1989) has been suggested to be one of the most comprehensive and methodologically sound randomised controlled trials of psychotherapy for depression. The data generated from the study has been used in various psychotherapy process-outcome studies (Zuroff and Blatt, 2006; Kolden, Chisholm-Stockard, Strauman, Tierney, Mullen & Schneider, 2006, Krupnick et al 1996).

A comprehensive study of the effect of the therapeutic relationship on outcome was carried out using data from the NIMH TDCRP by Zuroff & Blatt (2006). This study compared the effect of the therapeutic relationship using the B-L RI in cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), pharmacotherapy (Imipramine) with clinical management and placebo with clinical management. Outcome was assessed using a range of measures for depression (BDI; HRSD), general mental health (HSCL), anxiety (GAS; SAS) and enhanced adaptive capacities (EAC) to measure improvements at follow up.

The therapeutic relationship was assessed in session two and residualised by regressing B-L RI scores on the six different outcome measures to account for early change. Those with high B-L RI scores improved significantly quicker than those with low scores ($F (1,468) = 11.13, p < .001$) during the treatment period and also at the eighteen month follow up ($F (1,175) = 4.37, p < .05$). B-L RI scores significantly predicted outcome in all four treatment conditions with no significant differences between treatments. These support the effect of the therapeutic relationship on outcome; however, there are some points to consider. A series of patient characteristics were tested and did not account for the association between the B-LRI and outcome during
the treatment period; as a result of which, long term outcomes may be determined more by patient variables. Patient variables accounted for much of the association between B-L RI and maladjustment during the follow up period with patient scores on perfectionism being correlated with the B-L RI suggesting this variable may account for both low levels of the B-L RI and poorer long term outcome (Zuroff & Blatt 2006). Despite the finding that perfectionism may be related to outcome, the data from this study has provided strong support for the association between the therapeutic relationship and outcome especially during the treatment period.

3.2.2.2 Therapeutic relationship in non experimental trials
The therapeutic relationship has also been shown to be a good predictor of outcome in a study that explored the effectiveness of process experiential therapy (PET) and cognitive behavioural therapy (CBT) for depression (Watson & Geller, 2005). Watson and Geller (2005) recorded ratings of the therapeutic relationship using the mean score of the B-L RI completed at session nine and again at session twelve. A principal components factor analysis revealed that a single factor accounted for sixty eight and half percent of the variance and so a global measure of the relationship was used. It was found that the therapeutic relationship scores predicted outcome in both PET and CBT. Further analyses tested for a mediating effect of the therapeutic alliance (WAI) on association between the therapeutic relationship conditions on outcome. Regression analyses showed that the therapeutic alliance mediated the effect of the B-L RI score on all outcome (BDI-II; Rosenberg Self Esteem Scale; Dysfunctional Attitudes Scale; Inventory of Interpersonal Problems) measures except the Inventory of Interpersonal Problems Scale.
Watson and Geller (2005) suggested that there was no difference between CBT and PET in ability to predict outcome for depression. However their results showed it was the therapeutic relationship that was found to be the strongest predictor of outcome. Earlier it was suggested that for the therapeutic relationship to be considered pan theoretical it needs to demonstrate effects in non relational therapies. Interestingly, in the Watson and Geller (2005) study no significant difference in overall B-L RI scores between CBT and PET were found. However, PET therapists were rated more highly on the level of regard subscale than CBT therapists. There is need for some caution for interpreting this result. Despite stating earlier that the B-L RI has support for the four factor structure, a factor analysis carried out on this sample by Watson and Geller (2005) did not reliably identify the individual subscales as distinct from one another and therefore the authors’ claim over the regard subscale scores is invalid. This study adds further support to the effect of a global measure of the therapeutic relationship conditions on outcome and highlights the notion that relationship factors appear to predict outcome better than technique factors even in technique oriented therapeutic models.

The study reviewed above shows that the therapeutic relationship is strongly associated with positive outcomes for specific diagnostic criteria. In addition it would appear a strong association also exists between the therapeutic relationship and outcome in youth and family therapies (Karver et al 2006). In reviewing the evidence for the effects of the therapeutic relationship in youth and family therapy Karver et al (2006) carried out a meta analysis of forty nine separate studies and found a mean process-outcome weighted effect size of 0.28 (S.D. = 0.24) across all studies. Nineteen studies were identified as assessing the quality of those aspects of the therapeutic relationship covered by the B-L RI. Karver et al (2006) refer to the terms of empathy, unconditional
positive regard and genuineness as *counsellor interpersonal skills*. On average these qualities correlated with other process variables (alliance, engagement and attendance) 0.37; however, more interestingly the qualities of empathy, unconditional positive regard and genuineness showed effect sizes ranging from 0.06 to 1.32 with the weighted mean effect 0.35. This suggests that the mean effect on outcome in youth and family therapies is in the moderate range. In the same study measures of the therapeutic relationship other than the B-LRI were grouped together and produced a mean weighted effect size of 0.37. Notably, these effect sizes are somewhat larger than that found in the same study for the therapeutic alliance which had a mean weighted effect size of only 0.21 which falls into the small to moderate range.

The Karver et al (2006) review article reports findings from a wide range of therapeutic settings and treatment contexts demonstrating the resilience of the association between relationship and outcome across treatment setting. The results collectively present findings from youth, whole families or parents of youths receiving therapy. This does make it difficult to ascertain quite how much the therapeutic relationship impacts on therapeutic outcomes specifically with families and with young people. Additionally, the results use a range of measures assessing the therapeutic conditions some of which are not necessarily drawing upon the core theoretical principles put forward by Rogers (1957; 1959) which again calls for cautionary interpretation of the findings. However, taking all this into consideration the study strongly supports the association between therapist relational qualities and outcome as the two reported effects of counsellor interpersonal skills and therapeutic relationship with youths provided some of the largest effects of all process variables considered in this study. The two process variables that provided slightly larger or the same effect sizes are rather contradictory; one being for the association between therapist *directiveness* (0.40) and outcome whilst the other was
between client autonomy which was described as client self directiveness (0.37) and outcome. The reasons for this are not necessarily clear. However, one explanation is that different clients respond more positively to different levels of therapist directivity. Also, the interplay between client and therapist variables may have an impact the contribution that individually each may make.

3.2.2.3 Therapeutic relationship and severe psychological distress
So far it has been shown that global measures of the therapeutic relationship are related to outcome in the case of depression for CBT and PET and for a range of problems in youth and family therapies. The therapeutic relationship as it was defined by Rogers (1957) was developed from his personal experiences and observations from years of clinical practice. However, the six necessary and sufficient conditions for constructive personality change were intended to be an integrative statement and provided as a model for all kinds of helping relationship (Rogers 1957). Hewitt and Coffey (2005) have explored the potential for the therapeutic relationship to be conceptualised as an important factor leading to positive therapeutic change in people with schizophrenia. Their study involved a systematic review of the literature with the aim of establishing the necessity and sufficiency of the therapeutic conditions in this client population. The authors note that the therapeutic relationship was found to play a significant role in facilitating people’s recovery from schizophrenia including optimizing outcomes of other treatment (Bentall et al, 2003), better outcomes two years after treatment, compliance with medication regimens and lower levels of medication on discharge (Frank & Gunderson, 1990).
Hewitt and Coffey (2005) conclude their study suggesting that even though the therapeutic relationship has not consistently been viewed as a significant contributory factor in severe psychiatric settings this ought to be the case. They also suggest that the Rogerian conceptualisation of the relationship may be especially useful for psychiatric nurses who are increasingly being required to provide psychotherapeutic treatments. However, they also state that whilst the therapeutic relationship is important for psychiatric care, structured technique based therapy using CBT interventions will also prove fruitful in the future with people with schizophrenia.

It is possible that the therapeutic relationship has not been considered seriously in severe psychiatric settings as most conceptualisations of the therapeutic relationship stem from particular models of psychotherapy (Catty, Winfield and Clement, 2007) which are not seen as standard foci of treatment on acute wards. It is also possible that if conceptually coherent measures were used more routinely the therapeutic relationship may show itself to be even more strongly associated to outcome than currently known. In a comprehensive review of measures of the therapeutic relationship in psychiatric services Catty, Winfield and Clement (2007) have suggested that the therapeutic relationship has a significant contribution to make towards improving both standards of care and outcomes. However, they note that only four measures have shown a clear conceptual basis for use in psychiatric care with two that have clear face, content and construct validity and two with face and content validity alone. These authors interestingly note that the B-L RI shows a good deal of promise for use in this setting. However, until further validation work is undertaken with a secondary level care psychiatric population the measure lacks validity (Catty, Winfield and Clement, 2007).
A measure developed and designed for use in secondary mental health services is called the Helping Alliance Scale (HAS; Priebe and Gruyters, 1993) and despite reference to the term ‘alliance’ the measure is implicitly Rogerian in the conceptualisation of constructs it appears to be measuring. Fakhoury, White and Priebe (2007) investigated patients receiving therapeutic treatment through assertive outreach teams to see whether the quality of the therapeutic relationship between patient and clinician predicted re-hospitalization. Analyses were conducted on 332 "established" (equal to in care for >=3 months) and 150 "new" (equal to in care for <3 months) patients with severe mental illness sampled from 24 assertive outreach teams in the UK.

The therapeutic relationship was assessed at baseline using the clinician version of the HAS. Re-hospitalization was assessed over a 9-month follow-up period. Controlling for other predictors, a more positive therapeutic relationship was found to predict fewer hospitalizations in new patients but not in established ones (Fakhoury, White and Priebe, 2007). This finding is interesting as it appears that the therapeutic relationship was more strongly associated with outcome in those clients who first entered treatment via assertive outreach teams after the study had started. It is possible that the effects observed may be due to researcher effects and may have influenced the outcomes. However, perhaps by introducing a focus of the therapeutic relationship into secondary mental health care work the quality and standard of treatment available was raised. The authors suggest that secondary mental health is often criticized for being an ‘uncaring’ environment and such extra attention through the research study may have motivated staff to work on the relationships they offered to patients. This could be viewed as a positive, albeit unintended, consequence of the research study.
The foregoing arguments show that global measures of the therapeutic relationship are associated with positive therapeutic outcomes. This is the case when using measures that are directly assessing the combined levels of the therapeutic conditions defined by Rogers (1957; 1959). This appears to be the case for clients who have received therapy across a range of therapeutic approaches, for a number of presenting problems, for symptom reduction during treatment and resilience at follow up and finally in a variety of treatment settings. Further research is needed to explore the use of the B-L RI in psychiatric settings. Little of the research used an assessment of the therapeutic relationship from observer or therapist perspective. Had it done so, a fuller picture of the therapeutic relationship would have been obtained. One important point to note is that each of these studies has used a conceptualization of the therapeutic relationship as a unilateral phenomenon. The positive results are suggestive of a consistent association between the therapeutic relationship and outcome, however, the effects are relatively moderate in size leaving much of the variance in outcome unexplained.

3.2.3 Assessing individual therapeutic conditions
This review of the relevant literature now examines the contribution each separate therapeutic condition makes towards outcome. Each condition is reviewed and is also related to other process variables. In the current section each condition is reviewed from the unilateral perspective. However, later sections will consider the separate therapeutic conditions alongside other relevant variables where the case for a bi-directional view of the therapeutic relationship is formed. This is an important step in reviewing the literature in the present study as it begins the transition from unilateral to mutual and reciprocal perspective of the therapeutic relationship.
3.2.4 Conceptualising empathy

Empathy was described by Rogers (1959) as a state of the therapist and being empathic is to accurately perceive the internal frame of reference of another and experiencing the emotional and cognitive aspects of the other ‘as if’ they were one’s own but never losing the ‘as if’ quality (Rogers, 1959; pp. 210-211). Empathy can be thought of as a complex construct with a number of nested constituent components (Bohart, Greenberg, Elliott & Watson, 2002). In experiencing the internal frame of reference of another there are a number of experiences that one can try to sense. For example, Bohart et al (2002) note three distinct modes of therapeutic empathy; empathic rapport, communicative attunement, and person empathy. Empathic rapport is considered to be related to creating a therapeutic climate; communicative attunement is concerned with the moment to moment experiencing and is sometimes called process empathy. Finally, person empathy is concerned with the sustained effort of the therapist to understand the client’s background and understanding of the world (Bohart & Greenberg, 1997).

It appears that empathy plays a role in most of the different theoretical approaches to therapy. Of the different modes referred to above empathic rapport is most likely associated with CBT. In addition to this, communicative attunement is most likely to be associated with person-centred and experiential therapy and person empathy to psychodynamic therapy. However, these different elements of empathy are not necessarily separate or totally independent of one another and the boundaries between them may lie merely in a matter of emphasis at any given time (Bohart et al, 2002). This is perhaps seen in close studies of Rogers’ own work which found have that empathic
responses are focussed on different aspects of client functioning such as cognitions, emotions/feelings or the clients meaning making (Brodley, 2001; Brodely & Brody, 1990). In an analysis of her own therapeutic work and in comparison to Rogers, Brodley (2001) notes that her own and Rogers’ work are very similar in the number and target of empathic responses made and their very limited number of self referent empathic responses (1% and 2% respectively) indicating the strong tendency in person-centred work to respond to the other’s internal frame of reference. Therapist empathy is generally viewed as a significant feature for all therapeutic approaches and clients have repeatedly associated this condition with positive change in outcomes.

3.2.4.1 Empathy and outcome
Since the early reviews of the therapeutic relationship noted above (Gurman, 1977; Truax & Mitchell, 1971) a number of other and more recent reviews have been carried out (Beutler, Crago, and Arizmendi, 1986; Orlinsky, Grawe, and Parks, 1994; Orlinsky and Howards, 1986; N. Watson, 1984) that have looked at specific elements of the therapeutic relationship such as empathy (Bohart, Elliott, Greenberg and Watson, 2002), positive regard (Farber and Lane, 2002) and congruence (Klein, Kolden, Michels and Chisholm-Stockard, 2002). The Bohart et al (2002) study used data spanning nearly forty years collected from forty seven studies and included one hundred and ninety separate tests of the empathy outcome association. The study used data that considered the measurement of empathy by clients, observers and therapists using a range of measurement tools. The overall effect size was approximately 0.20 and thus accounting for about 4% of the variance in outcome. However, this effect is increased when weighting for large studies is accounted for giving an \( r = 0.32 \) which is a medium
effect size. Bohart et al (2002) state their surprise at the size of this effect as the total variance in outcome accounted for by empathy stands at between 7 percent and 10 percent which they suggest is possibly slightly more than that accounted for by the therapeutic alliance.

The analysis by Bohart et al (2002) suggested that client perception of empathy was the best predictor of outcome when compared with independent observer or therapists own ratings of empathy. Client perception of therapist empathy was on average the strongest correlate with outcome \( r = .25 \) and was closely followed by observer \( r = .23 \) and then therapist \( r = .18 \) ratings. However, it should be noted that each of these is significantly greater than zero \( p < 0.001 \). Perhaps the most surprising of results from this study, and one that supports the view of the effects of the therapeutic relationship on outcome as ubiquitous across therapeutic modalities was the finding that when exploring theoretical orientation as a moderator of the effect of empathy on outcome, cognitive behavioural therapy produced the greatest effect on outcome with a mean \( r = 0.32 \) followed by experiential/humanistic \( r = 0.20 \) and thirdly psychodynamic \( r = 0.16 \). This finding directly challenges the specificity model of psychotherapy especially as the strongest association between empathy and outcome was found in a non-experiential non-insight oriented directive therapy. As a result, Bohart et al (2002) suggest that empathy may lead to good outcomes directly through its role as a relationship condition, as a corrective emotional experience, in assisting cognitive-affective processing and finally through assisting the client as a self healing agent.

A difficulty with most of the findings is they predominantly rely on data collected from correlation studies. However, recently a small number of studies have used more sophisticated statistical procedures known as structural equation modelling to explore
the role of empathy on outcomes (Burns & Nolen-Hoeksema, 1992; Johnson, Burlingham, Olsen, Davies, Gleave, 2005; Kim, Kaplowitz & Johnston, 2004). Kim, Kaplowitz & Johnston (2004) explored the association of empathy with people attending an out-patient clinic in Korea. Patients in this naturalistic study presented mainly physical complaints. Data was collected using a survey method that was collected as patients were in the waiting room queuing for their consultations and then again afterwards. Physician empathy was shown to influence patient satisfaction and compliance in treatment via the mediating variables of information exchange, expertise, interpersonal trust and partnership.

In a study of group psychotherapy including six hundred and sixty two participants, data collected from a number of different groups compared the effects of group climate, cohesion, alliance and empathy. Using structural equation modelling Johnson et al (2005) found that group members rated their relationships based on quality rather than on role or status of the other. For instance, negative relationships were associated with empathic failures and positive relationships with bonding and empathy, regardless of whether assessing group leader or group members.

As mentioned above empathy is thought to be related to successful outcome in CBT and in addition to psychodynamic and experiential therapies (Ablon & Jones 1999). Burns and Nolen-Hoeksema (1992) carried out a study looking at the effects of empathy in a sample of one hundred and eighty five clients receiving CBT. Structural equation models were computed to assess the effect of empathy, homework assignments and a range of client factors on outcome. Empathy was found to have a direct influence on outcome. Homework proved to be a stronger predictor of outcome than empathy however, the reciprocal effect of outcome on empathy was found to be negligible indicating that,
contrary to the suggestion that the therapeutic relationship is viewed positively by clients as a result of making positive changes, therapist empathy preceded positive changes.

Whether or not the therapeutic conditions, including empathy, unconditional positive regard and congruence, actually cause change remains unclear (Cramer & Takens, 1992). The true test of this can only be completed through an experimental design where the independent variables are manipulated whilst all other variables are held constant via randomly assigning participants to either of the controlled conditions (Cramer, 1990). However, collecting longitudinal measures of the relationship conditions and simultaneous outcome data mean that tests for spuriousness can be carried out. In one such study by Cramer and Takens (1992) used this method to measure client changes across the first six sessions of client-centred and psychodynamic psychotherapy.

Improvements were observed as were levels of the therapeutic relationship conditions during this period. Mixed results for the effects of the therapeutic relationship conditions on outcome were found. Using a cross lagged correlation panel design Cramer and Takens (1992) found that session two client rated progress was a stronger predictor of session six therapist empathy and acceptance. These findings suggested that client improvement predicts perceived levels of the therapeutic relationship conditions and are contrary to those suggested above by Burns and Nolen-Hoeksema (1992).

More interestingly though was Cramer and Takens (1992) finding that session two therapist empathy and acceptance were positively associated with session six therapist rated client progress lending some support for the therapeutic role of these two conditions. Whilst this method of statistical analysis does not infer a direct causal relationship, it can suggest that the model which proposes that early ratings of therapist
empathy and acceptance predict later outcome is the best fit for these data. Empathy appears to have a strong association with therapeutic outcome and it is likely, although not proven, that this association is causal in nature. On the basis of the review of empathy by Bohart and colleagues (2002) this relational variable has been classified as receiving enough support to list empathy as an empirically supported relationship variable (Norcross 2002).

### 3.2.5 Conceptualising Unconditional positive regard

The following section reviews the literature for unconditional positive regard. The structure of the section is the same as that above for empathy by first conceptualising the construct, then relating it to outcome and subsequently followed in a later section by an association with other process variables that leads to the suggestion that this relationship variable must also be considered a bi-directional process.

Unconditional positive regard (UPR) is a central aspect of Rogers’ (1959) theory and the presence of UPR was apparent in his earlier works (Rogers, 1951; 1957). Much of the theory of UPR and Rogers’ development of the concept within his theory of personality is attributable to Standal (1954). Standal (1954) was one of Rogers’s students and completed his research dissertation on client-centred therapy the findings of which significantly influenced Rogers own thinking and theoretical developments (Bozarth, 2001). Until this time, Rogers had preferred the term acceptance which he had taken from Otto Rank. Whilst Rogers early work focussed on the benefits of acceptance of the client, therapist warmth and prizing, the conceptual development from Standal led to the theoretical development of the need for positive regard, positive self regard and the
regard complex (Rogers, 1959; Standal, 1954) and the term unconditional positive regard became the one Rogers used from that point on.

The experience of providing UPR for another was defined by Rogers (1959) as when “…the self-experiences of another are perceived by me in such a way that no self-experience can be discriminated as more or less worthy of positive regard than any other…” (Rogers, 1959; p. 208). In addition to this the experience of perceiving UPR was defined as “…of one’s self-experiences none can be discriminated by the other individual as more or less worthy of positive regard” (ibid; pp 208).

The theoretical proposal is that the therapeutic effect of UPR is experienced when it directly focuses on the facilitation and release of the client’s own organismic valuing process. The client’s introjected values from others are distorted in symbolisation in order to be consistent with the self concept. However, the result of experiencing sustained unconditional positive regard sets conditions of worth into reverse and these are no longer experienced as fixed and static constructs within the self concept. Rogers (1959) argued that as the client experiences the consistency of the therapist’s unconditional positive regard, experiences that have previously either been denied or distorted can then be experienced even though they were threatening to the self concept. In doing so, the client is able to congruently experience and integrate self experiences into the gestalt of the self structure.
3.2.5.1 Unconditional positive regard and outcome
The effect of positive regard on outcome was most recently assessed by Farber and Lane (2002). Their review builds on the findings of earlier reviews (Truax & Carkhuff, 1967; Truax & Mitchell, 1971; Mitchell, Bozarth & Krauft, 1977; Orlinsky & Howard, 1978; Orlinsky and Howard, 1986; Orlinsky, Grawe, & Parks, 1994 and Watson & Steckley, 2001) which have shown varying degrees of support for the therapeutic effectiveness of unconditional positive regard. Truax and Carkhuff (1967) reviewed a range of important studies including those which contributed data collected by Barrett-Lennard (1962) for the purpose of the development of the Relationship Inventory together with early data collected as part of the Wisconsin Schizophrenia Project carried out and finally published by Rogers et al (1967). Farber and Lane (2002) reported the Truax and Carkhuff (1967) findings as being based on the correlation between test change scores and unconditional positive regard. The results showed a mean correlation of \( r = .47 \) \((p < 0.05)\) suggesting a significant association between UPR and successful change in psychotherapy.

In contrast to this the reviews by Truax and Mitchell (1971) and later Mitchell, Bozarth and Krauft (1977) were slightly less conclusive. Truax and Mitchell (1971) found support in a number of studies assessing the relationship between therapist warmth and outcome taken from twelve separate studies and suggested that on average the two were significantly positively correlated. One study in their review, however, failed to find an association between regard and outcome despite finding a positive relationship between the other two core conditions of empathy and congruence with outcome. Farber and Lane (2002) note caution of the conclusion of this review as the results from the study were obtained from twelve studies, ten of which had been carried out by Truax himself. It is possible that researcher allegiance could be accounting for a sizeable
portion of the observed effects. The review by Mitchell et al (1977) maintained the 
inclusion criteria that only studies where ratings of positive regard from the independent 
observer's perspective were used to be included. This review is consistent with the view 
expressed by Truax and Carkhuff (1967) that clients will be unable to accurately 
perceive therapist unconditional positive regard. The study found that out of eleven 
studies meeting all the criteria only four showed a significant association between 
positive regard and outcome (Mitchell et al, 1977).

A significant contribution to the literature in this area comes from Orlinsky and Howard 
(1986) whose review of the literature included findings on therapist support and therapist 
affirmation. Farber and Lane (2002) note that therapist support does not have a direct 
thoretical lineage to Rogers' notion of positive regard which perhaps explains the 
relatively small number of positive findings between therapist support and outcome, six 
out of a possible twenty five findings showed positive results (Orlinsky & Howard (1986).
However, in considering the literature reviewed for the association between therapist 
affirmation and outcome the results are more favourable for positive regard with over 
half (53%) showing a positive association with outcome. This finding is even more 
striking if only those studies using the client's view of positive regard are considered with 
twenty out of a possible thirty findings (66%) showing a positive association with 
outcome.

Following this review Orlinsky, Grawe and Parks (1994) again considered the effects of 
therapist affirmation on outcome and found modest support. Whilst the findings 
suggested a positive association between the two variables, this association was 
particularly strong when clients' rating of positive regard and clients' rating of outcome 
was considered. When this was the case, fourteen findings from a possible nineteen
showed a positive association. Farber and Lane (2002) note that even more convincing than this was that when clients’ ratings of positive regard and therapists’ ratings of outcome are used the proportion of significant findings increases to 80%.

It is difficult to draw conclusions from the review of articles presented above. This is mainly because few of the studies involved used a measure of positive regard that has been directly derived from the theoretical basis of the person-centred approach. As is clear from Barrett-Lennard’s (1962) Relationship Inventory, a theoretically consistent measure of unconditional positive regard must also account for the stability of therapist attitude and not merely the positive or negative feelings of the therapist for the client.

In addition to this, whilst the views of independent observers may provide the most objective measure, this is not consistent with person-centred theory. Watson and Streckey (2001) argue that within client-centred theory the client’s experience is primary and attempts to invalidate it must be avoided. However, they also note that there appears to be a discrepancy in the convergence of client and therapist ratings of the relationship conditions with there being greater convergence at the end of therapy than at the beginning. This, they suggest could be indicative of the client’s inability to accurately perceive therapists conditions at least in the early stage of the therapeutic process. This finding would seem entirely consistent however, with Rogers’ theory that clients will become more able to accurately perceive the other as therapy progresses and that client’s experience greater congruence (Rogers, 1959). One problem with this however, is that it is difficult to determine what is meant by and how to measure an ‘accurate’ perception of the therapist’s UPR.
Farber and Lane (2002) point to a significant drop in the number of studies focussed directly on unconditional positive regard. Interestingly the title of their review does not refer to the ‘unconditional’ element of this variable. However, in their review they evaluate the findings from sixteen studies published between 1990 and 1998 and some interesting points of note are offered. For example, looking solely at the number of positive findings between positive regard and outcome 49% showed a significant positive association hence 51% were non-significant. The findings are even more favourable towards showing an association between positive regard and outcome when clients ratings of therapist positive regard and client’s own rating of outcome are used with over 80% of findings being significantly positive. However, closer inspection of their review shows that it appears only two of the sixteen studies included in the review specifically used a measure of unconditional positive regard suggested by Barrett-Lennard which is perhaps most closely aligned with the person-centred approach (Cramer & Takens, 1992; Williams & Chambless, 1990). These two studies included ten findings and four were significantly positive.

3.2.6 Conceptualizing Congruence
The third therapeutic condition identified by Rogers (1957) was the therapist’s congruence within the therapeutic relationship. The definition and explanation of congruence as a theoretical construct have been thoroughly explored in Wyatt (2001). However, some clarification is required here for the purpose of this study. Broadly speaking congruence has two main features. The first is the extent to which the therapist is being genuinely themselves within the therapeutic relationship and is able to
accurately represent and symbolise experience in awareness. The second is the therapist’s ability in communication to the client of their self in a way that is consistent with the experience of the organism of the therapist and without distortion.

In support of Rogers (1957) theory Lietaer (1993) has suggested that congruence is the most important of the three therapeutic conditions and agrees with the two features of congruence mentioned above. For Lietaer (1993) the first feature concerns the degree of congruence a therapist experiences is directly linked to the extent to which the therapist is in touch with their experiencing. The second feature is the ability to communicate their experience with the client which is referred to as transparency. However, it should be noted that Lietaer does not suggest that everything the therapist experiences should be communicated to the client. The therapist is advised to communicate only those experiences that would facilitate further exploration and be of benefit to the client. Being transparent is not a licence to say whatever pops into one’s mind.

Congruence is perhaps one of the most elusive conditions for both practitioners and researchers alike. This may in part be due to the extent that congruence overlaps with the two previous conditions of empathy and unconditional positive regard. Based on the communication and transparency features of congruence it is likely that large overlap with empathy and unconditional positive regard exists in measuring congruence. Both unconditional positive regard and empathic understanding also rely upon the therapist’s communication to the client. Indeed, Rogers believed the three conditions were interdependent and not entirely separate. Despite this, several methods for measuring congruence, together with empathy and unconditional positive regard, have been developed and have been used in a number of studies assessing the association between congruence, the other therapeutic conditions, and outcome.
3.2.6.1 Congruence and outcome
Klein, Kolden, Michels and Chisholm-Stockard (2002) carried out a recent review assessing the association between congruence and outcome. In this review they suggest that, as with the previous reviews that have been carried out, support for a positive association between congruence and outcome is equivocal (Meltzoff & Komreich, 1970; Truax & Mitchell, 1971; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Kiesler, 1973; Lambert, Dejulio, & Stein, 1978; Parloff, Wskow, & Wolfe, 1978; Orlinsky & Howard, 1978, 1986; Mitchell, Bozarth, & Krauft, 1977; N. Watson, 1984; and Orlinsky, Grawe, & Parks, 1994).

Klein et al (2002) identified twenty studies which had been carried out between 1962 and 1989 for inclusion in their review. Their results show there is some suggestion that more positive findings were found when clients assessed congruence using either the B-L RI or the Truax Relationship Questionnaire (Truax & Carkhuff 1967). Also, when either clients or therapists rated congruence the results showed a more positive association when global therapist ratings for outcomes were used with six out of eight (75%) findings were positive. However, Klein et al (2002) caution that each of these findings was taken directly from studies carried out either in Chicago or the Wisconsin Schizophrenia project. Both carried out by Rogers and his colleagues suggesting the possibility of some researcher effects.

Whilst these results do not show strong support in favour of the association between congruence and outcome, Klein et al (2002) point out that in each of the fifty nine
findings for congruence and outcome that also reported findings for either or both empathy and unconditional positive regard, the results were consistent with Rogers’ (1957) hypothesis and were necessary for positive change to occur. For example, in twenty one of these findings when congruence was positively associated with outcome so was either empathy or unconditional positive regard. Further, on eighteen occasions either empathy or positive regard was associated with outcome and congruence was not. The authors conclude that these findings suggest that the extent of ‘patient perceptions of the relationship and therapist perceptions of outcome may be accounted for by a third variable’ and suggest patient expressiveness as one possibility (p. 205).

3.2.7 Summary
The section above has shown how there is a moderately strong evidence base for the association between the quality of the therapeutic relationship and outcome in psychotherapy. Empathy and unconditional positive regard appear to receive more support than do congruence; however, this condition is inseparable from both empathic understanding and unconditional positive regard. The internal, or intrapsychic, facets of congruence may make it harder to obtain as an accurate measurement of this condition and therefore its association with outcome may be weakened. The sections below now take a closer look at the relational model and will consider a number of issues related to why and how the therapeutic relationship may be a facilitative therapeutic process. Each of the therapeutic conditions is considered again below, however, this time considering them alongside other process variables that suggest a bi-directional nature to the therapeutic relationship.
Part 2: Literature review 3

Addressing the research question

Chapter 4

The case for a relational approach
4.1 Relational approaches to understanding psychological distress

4.1.1 Introduction
So far, the literature reviewed has suggested the link between the therapeutic relationship and outcome. This appears to be a consistent yet small to moderate association. The suggestion here is that this association will remain small to moderate whilst assessing the therapeutic relationship as a unilateral construct. The section below begins to sharpen the focus on the link between the therapeutic relationship as a bi-directional phenomena and outcome. To do this, the suggestion is made that relational therapy is helpful as this directly addresses the causes of distress in people’s lives. The contention is that all distress is relational – whether that is on inter or intra personal planes. First, a review of the arguments which suggest distress is the result of relational dysfunction. Next, the concept of mutuality is introduced as the key to successful relational healing. Then a review of the evidence to support the view of the therapeutic relationship as a mutual healing environment is given. The debate draws from both theoretical and empirical sources.

There are a number of perspectives that can be adopted to help understand the causes of psychological distress and each is related to a particular model of psychopathology Joseph (2010). For example, Joseph suggests that seven major models represent the way we understand psychological distress. From this analysis Joseph (2010) states the current dominant model is the biomedical model which has its roots in the medical profession and psychiatry. However, the other well known models for understanding distress all have their roots in one or the other major schools of psychology, namely, psychoanalytic, behavioural and humanistic and more recently the cognitive model. The
two other models outlined by Joseph (2010) are the transpersonal and socio-cultural models.

A model of psychological distress not referred to by Joseph is the relational model. The relational model is potentially pan-theoretical and can be applied to all forms of distress and has relevance for all approaches to psychotherapy. Take for example the point that even within behaviour therapy, where the model suggests that exposure and experiments are the key to success, some researchers have shown that even here the therapeutic relationship is related to outcome (see Sloane et al 1979 for the effect of the therapeutic relationship in behaviour therapy). The relational model has emerged out of both the psychodynamic and humanistic psychology models. To add to this there have been interesting recent findings from the field of child development (Aitkin & Trevarthen, 1997; Stern, 1985).

The relational approach adopts an interpersonal approach to understanding the difficulties people face and therefore the therapeutic methods are likewise relationally oriented. There are two reasons why it is necessary to explore the relational perspective. First, understanding distress as relational suggests that it can act as a potential unifying construct across all the major therapeutic approaches. Second, considering distress from a relational perspective provides a rationale for how the therapeutic relationship works as a curative element in its own right. Some of the theoretical positions that relate to the relational perspective are outlined below and aim to make clear how each supports the view that distress can emerge from and be transformed in relationship.
4.1.2 Interpersonal perspectives on relational distress

The work of the Russian psychologist Vygotsky (1978) has shown how psychological processes are internalised following their initial appearance at an interpersonal level. That is to say, intrapersonal process is a function of interpersonal process. If this is true, says Maroda (1998), then both the enterprise of psychotherapy and the placing of our attention to interpersonal process has been validated. Mearns and Cooper (2005) outline several well known psychological problems which they suggest are potentially the result of an impoverished relational context.

For example, Mearns and Cooper (2005) suggest that loneliness, anxiety and depression are all perhaps caused by a lack of satisfactory interpersonal relationships and of being starved of deep and meaningful human contact. They suggest that even severe psychological problems, including psychotic episodes, can be thought of as the result of living in a relationally dysfunctional environment (Mearns & Cooper, 2005). The notion of schizophrenia being related to the dysfunctional relational environment is not new, however, and has been well documented by Laing (1965) and later by Bateson et al (1956). As much as Laing (1965) stressed the significant role of relationships in creating psychoses he also makes clear that, once in therapy, the behaviour of the patient cannot be viewed as something existing outside of the relationship between psychotic patient and the therapist trying to understand. Laing (1965) suggests, ‘the behaviour of the patient is to some extent a function of the behaviour of the psychiatrist in the same behavioural field’ (p.28).

In this statement it is clear Laing is suggesting that it is not possible to view the psychotic as an object or a thing separate from the therapist. Mearns and Cooper (2005) would agree with this and see both the client and therapist as having the potential to affect one
another. Mearns and Cooper (2005) note that difficulties in interpersonal relating can have a significant effect on adult functioning and cause significant distress, this may especially be so when early childhood trauma and abuse has occurred. They qualify their argument by suggesting that not all psychological distress can be reduced down to difficulties in relationships (Mearns & Cooper, 2005). Unfortunately, this point seems to take away from the thrust of their argument for the relational perspective making it a little tentative. Sameroff (1989) makes a much stronger argument in locating the roots of all adult distress in relationship disturbances experienced during childhood.

As is highlighted above Laing (1965) and Sameroff (1989) suggest that the nature and experience of relationships within the family are likely to be the root cause of significant distress experienced during life. For this reason it is important to consider the ways that early relationships impact upon the development of the self. Several theoretical perspectives are outlined below and each is able to develop understanding of relational perspectives. The theoretical perspectives outlined below consider the role of inter and intrapersonal process in the development and maintenance of psychological distress. It is necessary to consider these perspectives as they can help to understand the therapeutic principles responsible for positive growth.

4.1.3 Rogers’ theory of behaviour and personality as a relational theory
One of the major contributions to understanding psychological distress that is relevant to relationship based approaches to psychotherapy is Rogers’ (1951/59) client-centred therapy. The theory of therapy was developed out of a theory of behaviour and personality development. Rogers (1951) proposed that the person was inherently
motivated towards greater integration and socialisation through the maintenance and enhancement of the organism. He termed this basic motivation the *actualising tendency*. In addition to this, Rogers suggested the organism is guided towards actualisation via an organismic valuing process. Stiles (2004) (in Herman and Dimaggio) has suggested that it is through the organismic valuing process that the organism experiences either positively or negatively valenced affective responses to events.

Due to the focus of Western society, and to some extent in Rogers' writing, on autonomy person-centred theory has not typically been considered a relational theory. However, this has perhaps been a mistake and is largely due to the individualistic cultural influence to which it has been subject. Tudor (2010) has recently written about this topic suggesting that Rogers organismic theory is relational and can be demonstrated by the notion of homonomy as a counter point on a dialectic with autonomy. Tudor uses these constructs, themselves a great influence on Rogers via the work of Angyal (1941), to show how the theory is relational not only as a self but with regards to the total organism and includes within this the therapeutic relationship.

Rogers’ theory claims a portion of experience becomes differentiated from the total experience of the organism as the self and forms a self concept. Through continuing relational exposure with care givers and significant others, and within an organismic relational scheme their environment, the infant/child experiences responses to their own behaviour which indicates to them a sense of worth that is either conditional or unconditional. As this process unfolds within social and interpersonal relationships the infant learns they feel best under conditions where they experience positive regard and thus will behave in ways in which they will receive positive regard. Rogers (1959) states that in situations where the child behaves in such a way where he feels valued on the
basis of those conditions and values they have introjected from significant others, they are valuing their own worth from an external locus. Under such circumstances it is suggested that conditions of worth have developed and form part of the self structure. Once firmly established, these conditions of worth become the dominant guiding principle for determining behaviour. According to Rogers, once conditions of worth have developed the child now; ‘reacts with adience and avoidance towards certain behaviours solely because of these introjected conditions of self regard’ (Rogers 1959 p. 225). From this, it is possible to see how the social environment of the child can lay the foundations for later psychological distress.

As it is with the organism, the self concept strives to maintain and enhance itself. This implies that events experienced by the organism that are consistent with the self concept are integrated into the gestalt of the self concept. However, those events experienced that are not consistent with the self concept but are part of the total experience of the organism are either distorted to fit with the self concept or denied access to awareness and thus not integrated into the self concept. That is they remain other to the self concept. This creates a basic tension and anxiety which Rogers termed incongruence. From this perspective, incongruence is determined by the extent to which there is a similarity in the organismic/internal valuing process and the external valuing process determined by conditions of worth that are generated within interpersonal relationships. It is clear that development of a healthy self under this theoretical scheme is largely determined by early relationships within which the child grows and will later seek to replicate. From this view, the person-centred approach is a relational theory of psychological distress.
Barrett-Lennard (2005) has suggested that Rogers' (1959) theory gave no indication that the developing child would be differentially affected by his interactions with different caregivers or a number of significant others simultaneously. However, Barrett-Lennard (2005) suggests this is likely to happen and is a logical extension of Rogers's original hypothesis. For instance, when a child behaves in a particular way they usually receive a response which to some degree is conditional. When the child receives different degrees of conditionality in response from a range of significant others for the same behaviour the child will need to learn to navigate multiple pathways to feeling acceptable and worthy. In such a developmental scheme, it is likely that the child moves towards greater self diversity which will involve increasingly greater levels of denial within those relational configurations in which behaviour has received high levels of conditionality in response. Self diversity can thus develop in either a healthy direction and free from anxiety when a significant proportion of the diverse elements of the self have a greater congruence with the total experience of the organism. Or there may be greater tension and anxiety when the frequency and extent to which the self displayed in a range of contexts is incongruent with the internal and total experience of the organism.

The notion of self diversity or self plurality has become a prominent feature in person-centred thinking and has led to the development of a number of theoretical propositions. For example, Mearns and Thorne (2000) have proposed the notion of a plural self and have described the self as a multiplex of co-existing 'configurations of self' (p. 2) that are formed to make up a unified whole. In this theory, each configuration is able to function as the presenting self when faced with social interactions, responding to the situation or context from a defined set of conditions of worth, some specific and some shared with other configurations. For people who are extremely distressed it is possible that some configurations of self exist with no awareness of other configurations of self, much like
that described within a dissociative identity disorder (see DSM-IV-TR, 2004). However, it is essential not to suggest that these part of the self are totally separate. Tudor prefers to use the term 'aspect of the self' as he consider this reflects a more holistic view of an 'organismic in tension' (Tudor, 2010; p.63). It seems from the above that person-centred theory is relational. This is the case from not only the self-relational but also organisimc perspective.

There have been other developments within person-centred theory which have also considered the potential of self plurality. Two of these models consider the way in which self diversity is reflective of interpersonal functioning and development and can provide a metaphor for psychological distress. These are the assimilation model (Stiles, 1990) and Cooper’s (2005) ‘I-I’ relational mode and are presented in more detail below. These two perspectives offer a helpful metaphor for considering the role of intrapersonal relationship as a mode of distress and likewise the role of relational therapy as a helpful approach.

### 4.1.4 The assimilation model
Relational and interpersonal theories of development suggest the self develops out of social relationships with significant others and environment. As noted above, Vygotsky (1978) demonstrated that during the development of cognitive processes a child first observes through interaction on the interpersonal plane and subsequently internalises these experiences to the intrapersonal plane. This suggests that all higher order cognitive functioning emerges out of social interactions. The process of interpersonal modelling was termed the zone of proximal development (Vygotsky 1978).
Stiles (1990) developed a theory of the self as a multiplicity using an assimilation model which has its roots in both person-centred and Vygotskyian principles. Stiles (1999) uses the metaphor of ‘voices’ to represent different parts of the self that have not been integrated into the self construct and thus represent difficult to process experiences. In this model individual voices are integrated over the course of therapy. Stiles’ (1990) model is based on an eight stage model of assimilation/change. Clients will often present to therapy with a difficulty represented by a voice which can be at any point along the eight stage process of change. The point along the continuum at which a client enters therapy or where they reach at any point of therapy is assessed using the Assimilation of Problematic Experiences Scale (APES; Stiles et al, 1990; Stiles et al 1991).

In line with the assertion made earlier that relational approaches to distress are pan-theoretical the assimilation model is not tied to any specific therapeutic approach. There is evidence to show how the model has been useful and able to account for change in psychodynamic, person-centred, cognitive behavioural and integrative approaches to psychotherapy (Stiles 2002) and the assimilation model has received reasonable support through the research literature. The research has mainly employed qualitative case study methodology to address the process of change and in addition to account for outcome in psychotherapy.

To demonstrate how this approach has contributed to furthering our understanding of the relational perspective some recent relevant research is outlined below. This work considers the role of intrapersonal relating in the facilitation of positive growth and shows how the APES model has been extended through research carried out in new areas. Recent work has seen the model applied to the acculturation (Stiles 2005) and
identification of disparate internal voices from native and host culture (Henry et al 2005) by Gabalda (2005) in the application of Linguistic Therapy of Evaluation (LTE) and by Humphreys et al (2005) as a method for charting change in a client with dissociative identity disorder. The last of these was able to show that the model is applicable to a new diagnostic category.

However, as mentioned above in an earlier section in order to develop a strong argument for the relational model it is important to consider the effects of different therapeutic models on relational processes. This is perhaps best done in comparing relationally oriented and non-relationally oriented therapies. Recently, Osatuke et al (2005) have compared the effectiveness and change process using the APES model in client-centred therapy (a relational therapy) and cognitive behavioural therapy (a non relational therapy). Perhaps unsurprisingly both therapies showed that overall clients improved in relatively equal proportion. However, the pattern of change that is represented using the APES suggests that relational and non-relational approaches may operate differently. The client who received client-centred therapy appeared to have a fairly smooth trajectory of improvement steadily scoring higher on the APES as therapy progressed. The client receiving cognitive behavioural therapy, however, seemed to change in 'saw-toothed' pattern.

Osatuke et al (2005) suggest these differences may result from different ways of being psychologically healthy. However, a more interesting proposition is that the analysis of the pattern of change suggests the interactions between client’s voices with one another paralleled the interpersonal interactions between client and therapist. Hence, the client receiving client-centred therapy seemed to internalise this way of relating and provided their self with unconditional positive regard and empathy whilst the client receiving
cognitive behavioural therapy adopted their therapist’s pragmatic, managerial approach towards problems (Stiles, 2005).

The saw-tooth pattern of change presents a potential difficulty as it contradicts the APES which are based on progression that results from building meaning bridges between voices (Stiles 2002). In response, Stiles (2005) notes that abandoning the principle of staged progression would require major theoretical revision. However, Stiles (2005) offers five possible reasons: imprecision in measurement, multiple strands of a problem, work in the zone of proximal development, multiple internal perspective, and interference from progress on other problems. These are not intended as mutually exclusive explanations for the apparent pattern of development. Of the possible explanations suggested by Stiles (2005) perhaps the most relevant for this study is ‘work in the zone of proximal development’. Stiles (2005) suggested that directive therapists are more likely to identify and may select avenues of promise for client improvement. The directive therapist then pushes the client in this direction to the far end of the ZPD for the client, thus taking the development of a strand of a problem way beyond that which they would have achieved left to their own devices. In addition to this, Stiles (2005) suggested that as the therapist observes some clinical signs of improvement they may then drop back to pick up another strand and start over again, thus creating the saw-tooth pattern for improvement.

The client-centred therapist on the other hand is trying to stay alongside the client in a responsive rather than directive manner with no intention to lead the client in any specific direction by using a particular strand of a problem. Thus, clients receiving client-centred or other non-directive relational therapies are likely to advance along many strands simultaneously yet perhaps appearing to change at a slower rate. The major difference
that Stiles seems to offer between the relational and non-relational approach is the focus on dialogic rather than monologic process. The relational therapy seems to be responding to the whole client at all times and would support the proposal by Tudor that person-centred relational theory is organismic whilst non-relational therapy works in such a way that tries to isolate problems from the person and their relational environment.

It is apparent from the research into the assimilation model that it can be helpful to consider the self as a multiplicity or community of voices. However, more importantly for this study the assimilation model suggests the nature and form of close personal relationships that exist during formative episodes of life development, and later replicated to some extent within the client-therapist dyad, psychological distress can either be exacerbated or ameliorated. Stiles’ model clearly locates the therapist-client relationship as a central aspect helping the client to assimilate problematic experiences into the self structure. The assimilation model proposed by Stiles et al (1990) is useful in helping to understand the development of the multiplicity of the self and the way that disowned and unwanted part of the self can be assimilated by apportioning them with a voice within the therapeutic encounter.

4.1.5 ‘I–I’ and ‘I–Me’ modes of relating
A more recently conceptualised model for self plurality was suggested by Cooper (2003b; 2004; 2005) and transposes Buber’s (1958) I-Thou attitude for interpersonal relating onto the intrapersonal plane using an ‘I – I’ model of relating within the self. Cooper’s (2005) model suggests different I-positions are considered to be available at
different times. The nature of the intrapersonal relations is determined by the way that each online I-position relates to offline other ‘I’ positions. It is the nature of these intrapersonal modes of relating which can be the source of distress and tension within an individual. Cooper (2004) highlights the similarities between the self relational stance of the ‘I – I’ attitude with that of the interpersonal therapeutic relationship outlined by Rogers (1957) as necessary and sufficient for personality change. For instance, Cooper (2004) states that within the ‘I – I’ self relational stance there is a ‘fundamental empathy towards an alternate I-position, a positive regarding of its particular way of being, and a congruence and honesty in relating to it’ (pp. 66).

It is apparent under this scheme that ‘it-ification’ of different aspects within the self by other I-positions comes as a direct result of the it-ification they have experienced in the interpersonal encounters with significant others (Cooper 2003b). The implications for therapy are that client and therapist are required to develop a relational environment, both on the interpersonal plane and for the client on the intrapersonal that fosters both Buber’s (1958) I-Thou attitude and an ‘I – I’ attitude respectively. Cooper (2004) suggests this can be achieved by the therapist modelling the I-Thou attitude towards the client leading to the client subsequently internalising this way of relating and applying it on the intrapersonal plane. What is important about this way of relating is that this must be applied to the whole client and not the dominant I-position being presented at any one moment within the therapeutic encounter. Cooper (2004) goes on to state that this attitude must also be held towards ‘those subjugated or disowned I – positions that may be rarely externalised’ (p. 70).

There are two possible shortcomings in the ‘I - I’ model outlined by Cooper (2003b; 2004; 2005). The first is that the model does not account for the possibility of mutuality
within the self. Cooper suggests that a particular I position must offer a particular relational climate to another ‘offline’ I-position. However, in order for there to be true dialogue the offline I-position is also required to adopt a similar position. The model implies a unilateral and therefore asymmetric intrapersonal relational milieu. The second is that the model suggests that the client internalises the genuineness, empathy and unconditional positive regard of the therapist. However, considering the model outlined by Stiles et al (1990) and Vygotsky (1978) it is also likely that the client will observe the intrapersonal relating of the therapist and that it is this which is internalised and mirrored by the client. That is, the client perceives and receives the therapist as an other in addition to their role within the client’s relational organismic field. The therapists’ relational approach with the client and their intrapersonal relational stance both form and create the relational environment for therapy.

It would appear that even though Rogers’ (1959) original theory of personality indicated the self as a more unitary concept, alternative theoretical propositions exist that suggest the self develops towards diversity and multiplicity whilst retaining the central principles upon which these ‘selves’ are shaped and formed during developmental periods. Three further theoretical contributions are briefly outlined below. These have been selected as they represent and form the basis of other significant contributions in the field of relational therapy. Whilst the therapeutic techniques within attachment based and psychoanalytically informed approaches differ to those of the person-centred, viewing them all as relational suggests a consistency of relational perspectives and theories across different schools of psychological thought.
4.1.6 Attachment theory- relationally oriented

One of the main divergences from the traditional psychoanalytic theory of psychopathology was Bowlby’s (1969) theory of attachment. Whereas for Freud the basis of neurosis lay in large part in childhood sexual fantasies, Bowlby was more concerned with what he considered to be real events. As Mitchell (2000) points out, “Bowlby always seemed to regard the choice between privileging “real events” versus “fantasy” as a key fork in the road separating attachment theory from psychoanalysis” (p.84).

Attachment theory has had a significant impact on the development of research and theory about the nature of human relationships across the whole life span (Pietromonaco & Barrett, 2000). For Bowlby, the distress experienced as adults has its roots in the real events that occur within the relationships between infants and caregivers. According to attachment theory, the relational environment becomes the context in which new born infants have the opportunity to satisfy their innate tendency towards attachment. Through the development of what Bowlby (1973) termed internal working models templates for future relating are formed. As a result, the way in which the child organises subsequent behaviours and thoughts are a direct result of their attempt to maintain attachments. This can often be with significant and extreme costs to their own well being. Individuals not only develop internal working models of the self but also of the internal worlds of significant others (Bowlby1973). The content and processes involved in internal working models have been the focus of recent research (Cassidy 2000). Bowlby (1973) stated a key feature of an individual’s internal working model ‘is his notion of who his attachment figures are, where they may be found, and how they may be expected to respond...’ (pp.203).
It would appear that the child's need and search for attachment, security and emotional responsiveness will override all other tendencies to behave differently. In supporting this, Bowlby (1973) also states that in relation to the working model of self that an individual builds ‘his notion of how acceptable or unacceptable he himself is in the eyes of his attachment figures’ (ibid. pp.203). This does not sound too far from the proposition put forward by Rogers (1959) suggesting the need for a consistent empathic and emotionally responsive environment in which infants and children develop and receive positive regard in order to construct and develop a congruent self concept. Both these positions point towards a clear role for relational therapy in attempting to create a healing and growth promoting environment.

Much like that suggested by Barrett-Lennard (2005) and in addition to the expansion within person-centred theory there have been interesting developments in the field of attachment. One such is that individuals regularly identify several attachment figures (Trinke & Bartholomew 1997) and that as a result multiple internal working models of self may co-exist (Pietromonaco & Barrett 2000). Hinkley and Anderson (1996) have suggested internal working models of attachment may be thought of as representations of self-in-relation-to-others thus stressing the relational perspective in attachment and psychological distress.

Pietromonaco and Barrett (2000) suggest it is worth considering whether multiple working models of self-in-relation-to-other can exist simultaneously and represent an attachment to a generalised or specific other. This is similar to the point made by Ogilvie and Ashmore (1991) who suggested several models for a specific other may exist that may be affected or dependent upon the situational context in which they are called into play. This again highlights the way that the roots of psychological distress can be found
within the internalised interactional relationships with others and that these are not fixed and static constructs. Rather, internal working models of self-in-relation are therefore open to change and growth through the environment and processes involved in relationship based psychotherapy.

### 4.1.7 Evidence from a developmental perspective
A relational theory of psychological distress is also supported by the work of developmental psychologists studying relational and interpersonal aspects of infant and child development. A major recent contribution to this field has been from the work of Stern (1985) and focussed on the development of the self from the first moments of the infant's life. Stern's (1985) theory of the development of self has relevance to the relational perspective. Stern suggests infants relational capacities are observable even in the earliest months of life and are proposes these form a sense of self at this early stage. Stern (1985) suggests four senses of self emerging at different times beginning with a **sense of an emergent self** (0-2 months), a **sense of a core self** (2-3 months), a **sense of a subjective self** (7-9 months), and a **sense of a verbal self** (15 months). As each sense of self emerges so does a new **domain of interpersonal relatedness** and Stern (1985) notes that whilst each 'domain of relatedness results in qualitative shifts in social experience' they are not developmental phases to which clinical issues are anchored.

Rather, these domains are representations of social experience present throughout life and associated clinical issues are continually worked on throughout the life course.
Much like attachment theory, the propositions made by Stern (1985) are significant departures from the traditional analytical view which held that no sense of self exists prior to the development of language. Through close infant observations Stern’s (1985) work is able to highlight the ways in which infant’s can show their inherent capacity for relatedness in interpersonal connections with caregivers. A major tenet of Stern’s (1985) theory is that both the sense of self as it develops and the associated domain of relatedness do not give rise to fixed internalised patterns of interaction. Internalised representations of experience, referred to by Stern (1985) as Representations of Interactions Generalised (RIGs), whilst similar are not the same as 'internal working models' referred to in attachment theory. For example, RIGs are representations of a specific type of interaction whereas an internal working model is a much larger representation of relatedness and will determine a person’s response in a given situation. Stern (1985) suggests that RIGs can be thought of as the basic building block out of which working models can be formed.

From a developmental/relational perspective it is important to note that Stern (1985) states that the RIG is not an activated memory, however, the RIG can evoke what he calls an evoked companion which is an activated memory. The memory however, is not of an internalisation of an actual self-regulating other; rather it is an experience of being with, or in the presence of, a self regulating other (Stern 1985). This is important in understanding how we can relate to others we do not know previously in particular ways that may cause us to experience psychological distress.
4.1.8 Feminist-Relational developmental perspective
Whilst the theories above have been developed on infants and young children a feminist
a feminist relational model of development has emerged from research carried out on
adolescent girls’ and women (Spencer 2002). This is largely due to the work of Brown
(1998), Brown and Gilligan (1992) and Gilligan (1990, 1996). Much of this work has
focussed on the psychological development of women through relationships and culture
and suggests, much like Stern (1985), that development is not a linear progression of
stages that are completed, but a process through which the mind unfolds and expands
through relationships with others (Gilligan 1990).

As the process of development in relationships unfolds over time psychological health
can be defined as the capacity to ‘stay in relationship’. Staying in relationship is defined
by Gilligan (1991) as a key marker of development and consists of the capacity to
maintain authentic connection with oneself, with others and with the world (Gilligan 1991,
p. 21). Maintaining connection and resistance to disconnection indicate the tension
between the self and being in relationship and are at the heart of development (Spencer
2002). This tension is thought of in developmental terms as the resistance of taking in
and internalising negative views about one’s own self worth and of the idealising of
relationships when this runs counter to what is known through experience. The conflict
which emerges out of this tension is one of meeting one’s own needs and following
one’s own desires and acknowledging and respecting the needs of those with whom we
are in relationship. In such circumstances it is possible that in order to stay in
relationship we must disconnect from full authentic being and thus are not truly in
relationship. Gilligan (1982) has termed this as staying out of relationship in order to stay
in relationship.
In much the same way as Gilligan suggests staying out of relationship to stay in relationship, Brown (1998) has suggested that through cultural pressure a girl may come to take on the ‘voice’ of the dominant culture in an attempt to please the others to whom she relates. In time, this voice becomes the voice of an internalised problem and is now viewed as the girl’s problem. In this sense, psychological distress and the subsequent symptomatic features come to be seen as the developmental process ‘not knowing’ what is truly known. The potential of such knowledge being acknowledged becomes threatening for survival and so it becomes dissociated and connection within the self to experience is lost, solitude is mandated. In this model it is possible to see the connections and similarities to Rogers (1959) person-centred model of denial and distortion, Stiles (1990) assimilation of problematic experiences and Cooper’s (2004) I–I model of relating.

4.1.9 Summary
Each of these relational theories takes a different yet connected approach to the development of the self and of psychological distress. The connection lies in their commitment to understanding the inherent motivation of the self as relational. Each demonstrates the relational self as interpersonal, whilst recognising the influence and role of intrapersonal processes on the relational self. In reviewing evidence from theoretical perspectives this section has suggested that psychological distress can legitimately be considered as resulting from the quality of the relational environment in which a child develops. Additionally, the nature and the form these relationships have are subsequently internalised by the individual and become part of the self. The different relational contexts in which the child develops can be representative of different parts of
the self and the modes of self relating are then themselves representative of the different patterns and qualities of relations having been modelled in the interpersonal realm. Thus the more authentic, acceptant and understanding the quality of the relational context and interpersonal realm the better the quality of intrapersonal relating will exist. The natural course for the person is to maintain a relational environment which is consistent with their view of the interpersonal context and the intrapersonal self.

The suggestion that psychological distress is related to inter and intra personal relations has implications for therapeutic strategy. For example, the relational scheme calls for therapeutic strategy that is itself relationally oriented. This requires attention to and understanding of the relational dynamics present within the client-therapist dyad. Additionally, the therapist must pay close attention to and genuinely understand and unconditionally accept the relational patterns of the client on the intrapersonal plane and of their interpersonal relationships outside of the therapy. The following section turns towards an exploration of the psychotherapy literature relevant to mutuality and reciprocity within the therapeutic relationship as it is clear these are key constructs relevant to generating relational growth. Here the evidence is considered for the view that it is the interactional bi-directional nature of the therapeutic relationship that has a significant impact on change and positive outcomes.
Chapter 5

Literature Review 4

The case for mutuality
5.1 The case for the bi-directional approach
The sections above have argued that the therapeutic relationship is associated with positive therapeutic outcomes. In addition, it has been argued that research looking at the uni-lateral approach has provided an oversimplified vision for the effects of the therapeutic relationship on outcome. The research reviewed in the last section used theoretical principles supported by empirical findings to suggest that psychological disturbance can be caused as a result of dysfunctional relational experiences. These can be experienced on the interpersonal and intrapersonal planes. As a result, it is necessary to consider those studies that have explored the bi-directional nature of the therapeutic relationship and to determine its association with outcome.

5.1.1 Limitation in the current relationship research.
The majority of the research studies outlined above have found small to moderate effect sizes with regards to the therapeutic relationship and outcome. There are a number of possible explanations as to why this is so. For example, the point raised by Truax (1966a) that some clients may be unable to accurately recognise the therapeutic conditions provided by the therapist. This point has been dismissed as Gurman (1977) found that the most reliable predictor of outcome when assessing the therapeutic conditions was indeed clients.

5.1.1.1 Accurate perception of the therapeutic conditions
Disjunctions in interpersonal perception have been proposed to account for psychological distress (Cooper, 2005). For example, it is common for people to
misinterpret how another person may be feeling towards them. Laing, Phillipson and Lee (1966) have suggested that one person’s experience can never be fully known to the other person. Therefore, if one person experiences an event and then a second person develops a perception of how the first person feels as a result of the event, typically the first person is not very good at being able to identify what the second person perceives their reaction to have been. It is possible that clients do not accurately perceive the therapeutic conditions provided by therapists. For example, clients may misperceive the therapist’s being genuine or understanding for insincerity and being a know all.

Cramer and Jowett (2010) suggested that much of the research that has shown an association between support and relationship satisfaction has used measures of perceived empathy. This is certainly the case for much of the psychotherapy research that has used the Barrett-Lennard RI (1962). This measure assesses the levels of therapeutic conditions provided by therapists and perceived by clients. However, in light of the points made by Laing, Phillipson and Lee (1966) misperception may potentially explain why the association between the quality of the therapeutic relationship and outcome varies across studies. It is also possible that relying only on one perspective of the quality of the therapeutic relationship provides only a partial explanation of the degree of empathy, unconditional positive regard and congruence that is present and experienced between the client and therapist.

There are a number of ways that the accuracy of the therapeutic conditions may be assessed. For example, Cramer and Jowett (2010) have stated that a score for the absolute difference between the way that one person feels about something and the way that another person perceives that person believes they are viewed about that thing. There are two potential factors that can complicate this measure of accurate perception.
The first is that people often believe they are perceived by most other people in a very similar way and that this is very often as they see themselves (Kenny and DePaulo, 1993).

The notion of misperception of the therapeutic conditions suggests that the therapeutic relationship may be being experienced very differently on both sides of the relationship. The present study aims to explore the notion of similarity, or as it is argued in this study, mutuality of experiencing the therapeutic conditions.

The following sections present the evidence to support the bi-directional view and the significant role within this of the concept of mutuality. First the notion of mutuality is introduced and its links with a range of theoretical approaches are exposed. Next, a more in depth review of the empirical literature surrounding the notion of mutuality is provided and draws together evidence from a number of studies that have looked at various process elements within the therapeutic relationship field.

5.2 Introducing the construct of mutuality

5.2.1 Conceptualising mutuality in relational psychotherapy
The concept of mutuality is a significant feature in relational approaches to psychotherapy. Included in these are relational psychoanalysis, relational-cultural therapy, intersubjectivist approaches and person-centred therapy. Before any of the therapeutic effects of mutuality can be discussed it is necessary to attempt to gain some clarity over the precise definition of the term and to the meaning and implications of mutuality as a construct. By far the most comprehensive work relating to the theory of
mutuality in psychotherapy is by Lewis Aron (1996). Aron (1996) claims that psychotherapy, at least the relational psychoanalysis variant, is a mutual process which comprises different types or elements of mutuality within the therapeutic encounter.

For example, mutuality can refer to the experience of a mutual alliance, mutual empathy, mutual resistances, mutual regressions, mutual transferences, mutual affective involvement, mutual participation, mutual enactments, and mutual generation of data, mutual analysis, mutual regulation, and mutual recognition (Aron, p.xi; 1996). To add to these the present study is an exploration of the mutual experiencing of the therapeutic relationship conditions.

It is clear from this list that mutuality can be applied to a wide range of processes within the therapeutic relationship. However, whilst mutuality implies a more egalitarian view of the psychotherapy relationship mutuality is not the same as equality. Aron (1996) clearly states that it is possible to have a mutual relationship where a degree of asymmetry coexists. Aron (1996) provides examples of such asymmetry by describing the extent that the roles and functions of the client and therapist differ, the responsibilities they are required to fulfil and the behaviours in which they are permitted to engage. This is perhaps best exemplified through a non therapeutic relationship from ‘real world’ events. For instance, consider a situation involving two parties in which within the relationship mutual admiration exists; say between a team player and a coach. While mutual admiration may exist for each has to offer the other, when it comes to picking the team there is a clear asymmetry in role, function and power. Using the example suggested by Aron (1996) it is possible to imagine the situation of mutual admiration between coach and player, yet from outside the relationship it is clear to see the asymmetrical dynamic. The issue of experiencing the relationship from inside and observing it from outside was
an important point of distinction between the views of Buber and Rogers as discussed within their public dialogue (Buber – Rogers, 1957).

There are two further points that need to be discussed in relation to Aron's (1996) thesis of mutuality. In addition to the difference between mutuality and equality or asymmetry, is that a distinction is also drawn between mutuality and autonomy. Much of relational theory, including person-centred theory, is focussed on facilitating autonomy. However, mutuality creates a focus on the joining together of client and therapist within the therapeutic relationship. Aron (1996) refers to this issue as the 'dialectic of mutuality and autonomy'. This point is important as mutuality becomes contextualised within the concept of autonomy and extends to a debate which goes beyond the need to make an either or decision. That is, there is no requirement to chose to be either autonomously functioning or in mutual relationship. The two can coexist.

The second and more important issue which is raised by Aron (1996) and also refers to Rogers (1959) is the use of the terms mutuality and reciprocity. Aron notes that these terms are often used synonymously. This is something that Rogers (1959) clearly did in his theory of therapy and personality change. However, Aron notes that mutuality implies reciprocity rather than is the same as reciprocity. He highlights this by referring to the distinctive element of mutuality as a union between parties within an interchange, whereas, the distinctive element of reciprocity is that one party will offer the something of similar or the same back in return to that which was initially offered by the other party. Whereas reciprocity is more of a ‘return in exchange for’ mutuality has ‘no strings attached’. This is borne out of the notion that mutuality is co-created where as reciprocity is a lower order construct that can be separated into its two constituent parts.
5.3 Mutuality and the Buber – Rogers dialogue

Rogers and Buber met for a public dialogue in 1957 whilst Buber was engaged in a tour of the U.S. This significant event has been the focus of much attention and much of this is largely due to the contribution of Maurice Friedman who has written widely about Buber and the dialogue with Rogers itself (Friedman, 1983c, 1991; 1986, 1994, 1996d respectively). The dialogue between Buber and Rogers has generated a debate of its own much of which has centred on the issue of mutuality. In the dialogue the second question posed by Rogers to Buber gets straight to the heart of the matter when he asks Buber whether what Buber has termed the ‘I-Thou’ encounter is similar to that which Rogers himself had termed the ‘effective moment’ in the psychotherapy relationship. It is over this point where much of the commentary in the literature has focussed. The issue is important for relationship based approaches to psychotherapy as they have been concerned with the quality of the therapeutic relationship. Rogers suggested in the dialogue that effective moments in psychotherapy are moments where there exists mutuality between client and therapist. Cissna and Anderson (2002) offer the most comprehensive review of this commentary in their detailed analysis of the dialogue itself.

5.3.1 The principle of mutuality the person centred approach

The principle of mutuality plays a central role in numerous approaches to psychotherapy. The role of therapist subjectivity and the development of mutuality within the person centred approach were developed by Carl Rogers. Here Rogers had placed the notion of mutuality at its very centre. Mearns & Thorne (2000) have suggested that mutuality is often present within the therapeutic relationship in person-centred therapy as it enters
the middle phase of the process. It is at that stage where they suggest that trust and intimacy are well developed and where both client and therapist feel as though they are largely free from threat from one another and are able to experience one another with increasing reciprocal congruence. However, other than stating client and therapist experience reciprocal congruence they fail to indicate what they mean by mutuality and also are unclear about the therapeutic effect of mutuality. Their focus is more on the outcome of mutuality and says little about how mutuality is arrived at, worked towards, the therapeutic terrain that is covered in reaching mutuality or the actual processes involved in achieving mutuality per se. Or indeed whether there is always a mutual exchange of the therapeutic conditions yet is not always equal as their argument intimates.

Mearns and Thorne (2000) also note that not all therapeutic relationships may achieve a level of mutuality yet claim that these relationships can themselves be warm and effective. It appears from what Mearns and Thorne (2000) are suggesting is that a therapeutic relationship without mutuality could be therapeutic but that a therapeutic relationship where mutuality is experienced may be more effective. Reading Mearns and Thorne (2000) suggests they have based their argument where mutuality is considered an event, or a stage at which the therapeutic relationship reaches and then maintains. However, it was shown above that Rogers and Buber agreed that such moments of mutuality would last but a few minutes, as opposed, to relating to a developmental stage that the relationship reaches or achieves as Mearns and Thorne (2000) seem to have implied. That being said, it may still be the case that whilst mutuality exists for moments at a time, the lasting perception of the whole relationship may be one of a mutual encounter.
The role of mutuality in person-centred therapy may actually be similar to that described by Aron (1996) where he is suggesting that the child needs to be able to feel as though he has affected the mother figure and in much the same way the client will require to feel as though he has affected the therapist. In drawing from a case example Wilkins (2000) suggests that the more a therapist is able to feel accepted for who they are within the therapeutic encounter the more likely the therapist will be to experience changes themselves. Here, Wilkins suggests that in reaching mutuality, both client and therapist have reached the point at which they are able to offer each other unconditional positive regard. Drawing on the work of Brazier (1993), Wilkins (2000) suggests that in the client regaining the capacity to offer unconditional positive regard and the therapist’s reciprocal acceptance of this from the client, mutuality has indeed been achieved. Schmid (2000) supports this view that mutuality is essential and relates this to the dialogue between Buber and Rogers (1957) and the notion of unconditional positive regard and that of ‘confirmation’ which both agreed took the concept of acceptance beyond what one is in the moment to encompass that which one truly can become.

It seems clear that mutuality has a central role within the therapeutic relationship. The literature reviewed above has clearly articulated the arguments made for and against the role of mutuality. However, there is also a need to explore the empirical research that has been carried out into mutuality and the related phenomena to build a case for locating mutuality on the agenda for psychotherapists across approaches. For instance, if mutuality is a significant aspect of any highly functioning therapeutic relationship then it is essential for this to be demonstrated and evidenced. Before exploring the empirical evidence for mutuality a closer look at the potential for mutuality within psychotherapy is provided by reviewing the detailed analysis of the transcript from Buber and Rogers dialogue.
5.3.2 Is mutuality within psychotherapy achievable?
Cissna and Anderson (2002) highlight the fact that many errors are made in the literature that has provided the commentary to the Buber - Rogers dialogue. For example, they suggest that Friedman (1983c, 1991) often relies on memory for his analysis of the dialogue which leads to inaccurate quotations; Schaedler (1973a) for using Rogers as a foil in understanding Buber’s work and for not getting close to the real meanings of Rogers theory; Seckinger (1976) is criticised for not drawing a false distinction between the content of the dialogue in reference to the teacher – pupil and client – psychotherapist relationships. Cissna and Anderson (2002) go on to show how the likes of R. D. Laing (1969) caused confusion on the outcome of the dialogue by writing about a conversation he had with Rogers about the event itself. The content of Laing’s report shows how the meanings and content were far from the actual events as recorded on the original transcripts of the dialogue. Bonnie Burstow (1987) is also criticised for taking parts of the dialogue out of context in order to make the argument that the therapeutic relationship is mutual and therefore fully equal. Thorne (1992) is criticised for being careless and for inferring that an opinion expressed by Buber is tied to the issue of reciprocity, a point, by use of the transcript, they demonstrate was not the case. Cissna and Anderson (2002) conclude by suggesting each of these have contributed to the confusion around the issue of mutuality within psychotherapy.

Much like Aron (1996), Cissna and Anderson (2002) suggest that mutuality within the therapeutic relationship does not imply that the therapeutic relationship has to be quantitatively equal in all ways. This is a very important point and needs further exploration. In the dialogue between Buber and Rogers, Rogers makes perhaps the
most significant statement that has direct relevance for the present study. It should be stated that in all cases from this point on, any reference made to the dialogue between Buber and Rogers, refers to both the transcribed dialogue by Anderson and Cissna (1997) and their subsequent analysis of the transcript in Cissna and Anderson (2002).

Rogers states the point that for him the therapeutic relationship can be experienced the ‘same on both sides’ and also refers to this experience as being the ‘therapeutic moments’. The issue of whether there is a mutual experiencing of the therapeutic relationship that can be referred to as the therapeutic moment is significant. However, it is not clear precisely what that experiencing may feel like or look like from either perspective within the relationship or from outside the relationship.

For Rogers, as has been stated above, the main aim was to empathically understand, experience unconditional positive regard and be congruent within the relationship. These conditions were referred to as attitudinal qualities that the therapist holds towards the client. Is this what Rogers meant when he suggested the relationship is experienced the same on both sides? If so, then Buber disagreed. Buber, it appears from the dialogue saw these conditions as something the therapist held for the client but not the client for the therapist. For Buber, then, he disagreed with Rogers’ view as he suggests that it is Rogers as the therapist who is providing something for the client and that the client cannot give the same back which therefore makes the therapeutic relationship unequal.

This view, however, sounds more like the distinction between mutuality and reciprocity set out by Aron (1996) and described above. To give something back simply because it was provided by the other is reciprocity and not necessarily mutuality. However, this
point can be further expanded as it is unlikely that Buber believed the client would give something back only because it had been earlier received from the other. This is made apparent when Rogers states to Buber in the dialogue that what he believes he provides to the client is a ‘permission to be’ to which Buber’s response is that ‘I think no human being can give more than this. Making life possible for the other, if only for a moment’ (Buber 1957, in Cissna & Anderson, 2002 p. 144).

For Cissna and Anderson (2002) this exchange is an important one and one which they highlight has been significantly misrepresented in other accounts of the dialogue transcript. For example, Anderson and Cissna (1997) provided a detailed transcript from the original recordings and showed how many of the original interpretations of the dialogue are mistaken in their conclusions especially with regards to the extent of agreement that was reached between Rogers and Buber over the issue of mutuality. In considering this it is worth looking further at the detail of the transcript as it has been produced by Anderson and Cissna (1997).

Rogers and Buber agreed that the client comes to the therapist for help based on the fact that the therapist is likely to experience less distortion in his perceptions of experience. Rogers himself suggested that when the client is able to experience his own expression, experience the therapists understanding and reaction to it then therapy is nearly over. To this they agree that the therapeutic relationship is unequal, however, this does not imply it is non-mutual. The issue of mutuality was pressed further by Rogers when he suggested that he often felt that within the therapeutic relationship both client and therapist could experience equal authority and validity in their experiencing of life. Buber was in agreement with this, however, whilst Rogers was content to rely on his own subjective experience of this, Buber was unwilling to accept this and referred to a
'real situation' with regards to the therapeutic relationship and thought this was something that could exist outside of the subjective awareness of those involved.

This is perhaps one of the main points of disagreement between Buber and Rogers. Anderson and Cissna (1997) suggest that Buber’s response to Rogers’ claims was that there remained an inequity based on the fact that both client and therapist looked solely upon the client’s experience and that the therapist’s experience never became the focus of attention in the therapeutic relationship. In addition to this Buber took the matter further to suggest that neither the therapist nor the client were focussed on the therapist’s experience. This latter point is theoretically incorrect especially in considering the person-centred position with regards to congruence, where the therapist is very aware of their own experience, and may on occasion use and share this awareness with the client.

Aron (1996) highlights this point also in setting up the problem of mutuality and self disclosure. Aron suggests that these two need not be seen as an either/or possibility, that is, one either believes in non disclosure and therefore there is inequity, or one believes in mutuality and therefore must be self disclosing. Rather he suggests that this collapses too many ideas into one and therefore misses the point. It is, as Aron (1997) suggests, like interchanging the terms mutuality and self disclosure. The issue of meaning with regards to terminology may be underlying some of the problem between Buber and Rogers. One possible reason given by Aron (1997) is that using the term mutuality in a general sense can lead to misunderstandings. This may be the case between Buber and Rogers, with Buber referring to the relationship viewed from the outside and Rogers referring to the relationship as it is experienced from the inside.
In discussing relational psychoanalysis Aron (1996) suggests that Ferenczi was one of the most innovative psychoanalysts of his time, that is, the early twentieth century. He experimented and later advocated the notion of mutual analysis where the analysand would often be able to ‘help’ the analyst. This may be through the mutual analysis of a particular response that the analyst had to the client’s material. Both analyst and analysand would use this mutually generated data as a legitimate source of material for analysis. Ferenczi, reports Aron, suggested this was a mutually beneficial process leading, perhaps paradoxically, to a greater sense of equity between the analysand and analyst.

Rogers (1959a) was also keen to stress the consequence of therapy and that both client and therapist are likely to be changed by the process with each having the potential to learn through one another and experience personal growth. This is made explicit by Rogers (1959) when he states that

‘(the) greater the communicated congruence of experience, awareness and behaviour on the part of one individual, the more the ensuing relationship will involve a tendency towards reciprocal communication with the same qualities, mutually accurate understanding of the communications, improved psychological adjustment and functioning in both parties, and mutual satisfaction in the relationship’ (p. 240).

This is not to suggest that in therapy the therapist is the focus of the helping function. Therapy is always for the client and therapists must remain conscious of this. However, considering the point above from the person-centred view, whilst both client and therapist may at times mutually generate the data for therapy, Rogers (Cissna &
Anderson, 2002 p. 141) suggests it is unlikely to expect that clients and therapists experience quantitatively equal levels of the therapeutic conditions towards one another. However, given the statement made above by Rogers, it is not unreasonable to expect them to mutually experience the core conditions at least to some level. Indeed, Rogers (1959) was clear to point out that this is how he envisaged the process and outcome of successful therapy. This means that the asymmetry within the relationship, as Buber suggested and Rogers agreed, can be preserved yet there can also be mutuality. This fits with the dialogic view of the conditions of empathy and unconditional positive regard suggested by Schmid (2001) in which both client and therapist play a role in either party experiencing either condition.

Cissna and Anderson (2002) show how Buber, within the Buber – Rogers dialogue, questioned whether the therapeutic relationship could reach mutuality as he argues it is the therapist desires to meet the client yet the client does not have same desire. Rogers explained that his belief, based on his primary experience within therapy, is that it is in the moments where change takes place within therapy, that the client is able to fully sense the therapist’s understanding and acceptance and that it is this that is reciprocal and that it is the same which produces change. From this it is clear that Rogers’ view was that the therapeutic relationship was mutual, even if this was experienced by both sides for only moments. At this point, the transcript shows Buber responded to Rogers first with disagreement because it is the therapist who makes mutuality possible thereby suggesting it cannot be that the whole relationship is mutual. Shortly after however, as was noted above, when Rogers clarified his meaning that what he gives the client is ‘permission to be’ Buber agrees with Rogers that this is significant and that no one can do more than this.
5.4. Mutuality and the bi-directional nature of the therapeutic conditions

5.4.1 Introduction to empathy as a bi-directional and mutual construct
The following section of the literature review considers the three therapeutic conditions as bi-directional in nature and will explore the potential for mutual experiencing within the therapeutic relationship. Where available evidence is existing the association between the bi-directional and mutual aspects of these constructs and outcome will be explored.

The notion of mutuality has been extended into an exploration of the concept of therapeutic empathy. Whilst it has been noted above that empathy is a dialogic process (Schmid, 2000) it is also necessary to explore the relevant literature of mutual empathy. There are a number of sources that suggest that empathy is a mutual process within the overall therapeutic process (Aron, 1996; Roger, 1959; Stolorow, 1995; Surrey, Kaplan and Jordan, 1990; Suttie, 1935). The view from the feminist developmental perspective is that there is not only a need to be understood but also a need to be empathic towards the other (Surrey, Kaplan and Jordan, 1990). When transferred into the therapeutic context this implies that both client and therapist experience empathy in a relational way. That is neither it exists separately within one nor other party but rather is created as a dynamic within the relationship. For therapy to be growth promoting, the relational perspective suggests that both client and therapist must experience empathy with each other.

In much the same way as stated above that Buber misunderstood Rogers’ view that the therapist and at times the client would be aware of the therapist’s experience, the argument forwarded here for mutual empathy extends this. It is suggested here that the
client is required to understand, or perhaps see, that they have impacted upon their therapist. This may seem to stand counter to many approaches, especially traditional psychoanalysis where the therapist maintained distance and neutrality. However, contemporary psychoanalysis, relational theory and person-centred psychotherapy all accommodate this view. This view has been suggested by Suttie (1935) in an infant’s craving to have their love accepted by the care giving object. Also, Stolorow (1995) suggests that the therapeutic encounter is one in which reciprocal and mutual influence occurs between therapist and client which include the empathic process.

The notion of the client empathising with the therapist is potentially contentious as this may seem to shift the functionality of the roles of client and therapist and raises questions regarding the ethics of such a proposition. However, it could be conceived that the client is required to have empathy with the therapist when it is considered from the view of Emmanuel Levinas (1996).

For example, Sayre (2005) argues there is a need to ‘de-centre’ the client so that the client has the opportunity to be that which is fully human and respond to the call of the other. This is because, according to Sayre (2005), Levinas (1996) proposed that the ethical good is the lived response to the primacy of the other, over and above one’s own self. It is in responding to the other that a person is able to experience being a complete person. Much like Buber and Friedman have suggested within the Buber – Rogers dialogue, Sayre (2005) suggests that this is not possible when it is the client’s experience alone that is always at the centre. The dilemma for the therapist is that the therapeutic relationship is formulated in such a way that the needs of the therapist are typically kept out of the therapeutic relationship for ethical reasons. Sayre (2005) suggests that a key therapeutic task can be to facilitate the client’s exploration of an other in their life and to
develop an understanding of that person as a subject rather than as an object. This according to Sayre (2005) provides the client the chance to be fully human, in the view put forward by Levinas (1996), by responding to the pain and suffering of an other, but that other must not be the therapist. Without this opportunity to respond to the call, Sayre (2005) argues that the client is not being given the opportunity to act in a way that encapsulates all that it is to be fully human within the therapeutic relationship. This stands in contrast to the therapist, who, based on their responding to the call of the client, is able to be fully human within the therapeutic relationship.

In accepting the view of Sayre (2005), it seems that it would not be possible to achieve mutuality within the therapeutic relationship. This is based on the premise that such asymmetry and the subsequent inequity makes mutuality difficult to conceive. Whilst it was argued above that asymmetry is indeed an element of the therapeutic relationship when taking the relationship as a whole, this potential problem posed by Sayre (2005) presents a greater problem. The point that a client is unable to respond to the call of an other and is therefore not able to fully be himself is a potential problem for the notion of mutuality. However, Sayre (2005) makes a further point, by suggesting that if the client is helped and facilitated to respond to the call of an other and that this other is outside of the therapeutic relationship, the opportunity can arise where both client and therapist are able to respond to the call of an other and therefore the relationship is being experienced the same on both sides.

This point is strikingly similar to the one made by Cooper (2005) who, drawing from process experiential psychotherapy (PEP) (Greenberg, Rice and Elliott, 1996), suggests that clients and therapists may benefit from facilitating processing of disjunctions or misperceptions. In PEP this may take place through the processing of maladaptive
emotional schema on the intrapersonal level. In the latter, there is the possibility for a mutual encounter within the self, where the various parts of the self relate to one another in an authentically self accepting manner.

The suggestion by Sayre (2005) that the client may be de-centred from the therapeutic relationship as a means to consider their relationships outside of the therapeutic setting is possibly helpful for the development of interpersonal and relational functioning. However, it may not be necessary and possibly takes the therapy towards becoming a directive therapeutic method. The process of directing a client to engage in such an activity is clearly a process directive move, especially if such a technique was to be introduced and initially suggested by the therapist. There is yet another possible solution to the problem presented by Sayre (2005). For example, it may not be necessary for the client’s attention to be directed outside of the therapeutic relationship in order for them to experience being fully human. It is possible that the client can experience the opportunity to respond to the call for the other within the therapeutic relationship.

In therapy it is paramount that the client's needs are the focus of the therapeutic endeavor, that the client’s personal material is the focus of attention and the experiences upon which the therapy takes place. As a result, it is essential that the therapist's needs are to be met within a relationship other than the one that exists between client and therapist. Aron (1996) has suggested that it is possible that when a client and therapist meet with one another, standing counter to the other, the client may experience the need to put the therapist's need first. In his exploration of the role of mutuality in relational psychoanalysis Aron (1996) makes the point that it is possible that a client may need to feel as though they have 'reached their analysts, moved them, changed them, discomforted them, angered them, hurt them, healed them, known them in some
profound way, they themselves may not be able to benefit from their analyses’ (Aron, 1996; p. 136).

This view suggests that the therapist is required to show the client how they feel, how they have been moved by the client within the therapeutic relationship. Therapists often draw from their own experiences to develop a greater empathy or acceptance of the client. However, the therapist will also be changed within a therapeutic relationship in which they are fully open to experience within the relationship with the client. In doing this, the therapist inevitably self discloses to the client. The response of the client in this situation is a potential for the meeting of two persons, the client will be able to empathise with and offer acceptance to the therapist and experience the meeting of their need to respond to the other.

To highlight the point we can consider an occasion when the therapeutic process may touch upon the pain or suffering of the therapist, even to the degree that a tear may be formed in the eye of the therapist, because of the way the therapist responds to the call of the other, and the client has an empathic understanding of the therapist, the client knows that this pain is not being imposed upon them, but is present as a sign of the therapist’s use of their self to feel and experience as near as can be possible the pain and the suffering of the client. The client is aware of this and is congruent with the experience and accepts that this is the way the therapist is present at that time and for the client. Such a moment of encounter is one where both client and therapist have an intersubjective awareness of the other that is characterized by the relationship qualities described by Rogers (discussed above).
5.4.2 Empathy: evidence for bidirectional process
The present study is interested in the study of empathy as a mutual and therefore bidirectional process. Schmid (2001) suggests that empathy begins primarily in the other and thus argues empathy is a dialogic process. This implies that if empathy is only to be experienced by the empathising person then the other person or object or target of the empathy need not be present. Examples of such are the experiencing of empathy for works of art or past relationships. However, in psychotherapy empathy must be communicated to the client and then received by the client in the moment that therapy occurs. The extent to which this happens is not solely determined by the empathising therapist but is also dependent upon characteristics associated with the receiving client (Barrett-Lennard, 1981). The level to which a client perceives the therapist's empathy is in some respects reliant upon the client's ability to accurately perceive the therapist's accurate perception of the client's own internal frame of reference. This perspective supports a dialogic and bidirectional view of empathy.

Client involvement in therapy is an important factor (Orlinsky, Grawe and Parks 1994) in producing good outcomes and Bohart et al (2002) note the possibility that the effectiveness of empathy on outcome may be moderated by client variables. For instance, clients may react differently depending on their preference for closeness of relationship with the therapist with some preferring a more business like therapist (Mohr and Woodhouse 2000). Additionally, Beutler, Crago and Arizmendi (1986) concluded that clients will sometimes respond negatively to therapists who show warmth and are more empathic. This, they suggest, can be the case when the client has difficulty relating to others as a result of being poorly motivated or highly sensitive.
It is quite conceivable that the degree of empathy a therapist experiences towards a client can be affected by the particular issue a client presents and the behaviours exhibited within a session. Therefore, it will be easier for some therapists to empathise with some clients and not others. There are a range of reasons why it may be easier for therapists to empathise with some clients more than others. For example, factors such as client defensiveness, avoidance of close interpersonal relating, including with the therapist, or client hostility towards the therapist can all act as barriers to therapist empathy for client experience. In addition to this, the therapist’s own personal development and self acceptance is likely to be a factor. For instance, a therapist who has themselves experienced childhood abuse or neglect, and has not integrated these experiences into the self, may find it difficult to work in the psychotherapy field or experience empathy for abusers. However, one reason that a client may feel misunderstood or that a particular therapist struggles to develop empathy for their client that has received some empirical attention and support is client deference (Rennie, 1990).

Through qualitative analysis Rennie (1990) has inquired into the client’s experience of the therapeutic hour by interviewing clients directly after therapy sessions and then using tape assisted recall to identify underlying client and therapist processes. Rennie (1990) has suggested that clients will often try to understand the therapist’s frame of reference in their efforts to decide on how, where and what to explore next. This is an important and often overlooked concept. The notion that the client is also trying to understand the therapist supports the dialogic and reciprocity hypotheses of the therapeutic relationship being proposed within the current thesis. Also, Rennie argues that clients find it satisfying to feel understood however, if they feel they have been misunderstood they may also increase the likelihood of this happening again by avoiding particular issues or
not responding congruently to the therapist’s empathic offerings and try to send the therapist in a different direction (Rennie, 1990). This is another important finding as it suggests, as does Schmid (2001), that empathy congruence and unconditional positive regard, are co-created via the interaction between client and therapist.

5.4.2.1 Empathy and the therapeutic bond
A key psychotherapy process variable that considers the attitudes of both the client and the therapist is the therapeutic bond. The therapeutic bond provides some of the strongest evidence linking process variables to outcome (Orlinsky, Ronnestad and Willutzki, 2004). The therapeutic bond is considered part of the broader construct of the therapeutic alliance and has been identified as a distinct area within the Generic model of Psychotherapy which Orlinsky et al (2004) state has included over one thousand process-outcome findings. Within the model, the therapeutic bond construct is broken down into a number of smaller constituent components. First is the degree of goal collaboration and has less import for this study therefore this literature will not be commented on. Second are those elements concerning rapport within the relationship which is broken down further into communicative attunement and mutual affirmation. The first of these two aspects, communicative attunement, relates to the process of empathic understanding and is therefore included in this review. This area of research is important as, whilst most of the research is taken from studies focussing on the therapeutic alliance, they relate to only a portion of the alliance construct and as mentioned above have a significant degree of overlap with the therapeutic conditions as Rogers defined them. In addition to this, they also address the issue relating to the bi-directional process of the relational variables under exploration in the current study.
5.4.2.2 Empathy and expressive attunement
This aspect of the therapeutic bond is related to empathic understanding, client expressiveness, client empathic understanding of the therapist and communicative rapport. Orlinsky et al (2004) note a steady yet significant decline in the number of published studies reporting the effects of empathy on outcome. To their count only seven new studies were able to be added to the fifty three since 1958. Ablon and Jones (1999) carried out a study using data from the National Institute for Mental Health Treatment of Depression Collaborative Research Program (NIMH, TDCRP) study. This study provided a great deal of process and outcome data from brief therapeutic interventions for depression using CBT and IPT approaches. Using Q-item ratings from tape recordings of the sessions IPT therapists were rated as more empathic than CBT therapists and they conveyed more of a sense of non-judgemental acceptance of their clients. However, when Q-items were correlated with outcome, clients who received CBT showed that when they felt understood and accepted clients tended to do well. Of particular interest in this study is the fact that twenty two of the twenty three Q-items rated as being significantly correlated with outcome were items that directly reflected the client’s ‘characteristics, experiences or qualities’ (pp. 71). Of these, client rejection of the therapist was significantly correlated with the BDI \( (r = -.55) \) and with HRSD \( (r = -.51) \). This finding suggests that client acceptance of the therapist was an important factor in CBT treatment.

Two further studies that have been carried out are published in German and whilst cited in the Orlinsky et al (2004) review it has not been possible to obtain English translations. However, it would appear that the study by Fiedler, Albrecht, Rogge, and Schulte (1994)
explored the role of empathy in behaviour therapy for clients with phobias whilst two studies by Konzag, Fikentscher and Bandemer-Greulich (2000) looked at the role of empathy with clients who were also in-patients in a hospital setting.

There is also evidence that the therapeutic bond plays a significant role in therapeutic work with children as well as adults. A study by Russell, Bryant and Estrada (1996) looked at psychotherapy with thirty five children. Transcripts of psychotherapy sessions were produced from audio recordings and coded as high and low quality utterances from therapists. Following an initial principal components analysis of high and low quality utterances three separate factors were identified. The first of these was labelled Responsive Informing (RI) which reflected the therapist as a responsive and active listener and the second as Positive Regard (PR) which reflected the efforts of the therapist to show acceptance and positive affect towards the client. The third factor was labelled Initiatory Questioning (IQ) and reflected the therapist’s exploration of events in the client’s recent past. A subsequent confirmatory factor analysis was carried out that failed to support the three factor model, however, a satisfactory fit was found for a two factor model which included Positive Regard and Initiatory Questioning thus suggesting support in favour of an accepting and empathic exploring therapist.

When clients rate the quality of sessions the quality of therapeutic bond tends to be rated higher (Saunders 2000). In a study examining three aspects of the therapeutic bond, role investment, empathic resonance and mutual affirmation, support was found for the association between these elements and therapeutic outcomes. Saunders (2000) used self report measures designed to tap these three aspects of the therapeutic bond and associated them with outcome as measured by client ratings of remoralization, remediation and rehabilitation. One hundred and fourteen clients completed self report
measures of distress prior to commencing therapy, after the fourth, tenth and then every tenth session. The measure assessing the quality of therapeutic bond was administered once after session three. The findings of this study suggest that role investment and mutual affirmation are more strongly associated with client ratings of session quality than is empathic resonance. However, as measures of the bond and session quality were collected at the same time and measures of bond on only one occasion it is not possible to infer a causal relationship. Interestingly, using a hierarchical regression analysis empathic resonance was the only element of therapeutic bond to significantly contribute to the relief of symptom distress when distress at intake was also accounted for. This finding is important as it would appear that the client’s sense of understanding and of being understood is related to earlier rather than later change assessed by the phased model of change, that is, remoralization and remediation but not rehabilitation are related to client and therapist empathic resonance.

These results should be interpreted with caution however, as some problems exist with Saunders' (2000) study. The scale used to measure empathic resonance is from the Therapeutic Bond Scale (Saunders et al 1999) which was constructed from the Therapy Session Report (TSR) (Orlinsky and Howard 1986). Whilst the scale claims to measure the extent to which the client and therapist genuinely understand each other it is questionable that the eight items used are representative of these constructs as they have been defined elsewhere in the literature and outlined above.

Client reports of perceived levels of reciprocal intimacy with their therapist were also found to be related to remoralization. Using the therapeutic bond scales in the TSR with two hundred and sixty eight clients Saunders (1999) found that factor analysis identified six separate factors. The reciprocal intimacy factor assessed clients' reports of their own
feelings and those of the therapist. Clients’ reported emotions matched their reports of emotion identified in therapists with positive client emotions being associated with positive therapist emotions and likewise with negative emotions. Interestingly, reciprocal intimacy was significantly correlated with client ratings of session quality \( (r = .28, p < 0.008) \) and with treatment effectiveness when fewer sessions in treatment were received \( (r = .40, p < 0.008) \). Reciprocal intimacy was also highly correlated with other factors for example the client’s feeling of being remoralized \( (r = .38, p < 0.001) \) and the therapist feeling confident \( (r = .28, p < 0.001) \). Saunders (1999) claims these findings suggest that as reciprocal intimacy had the strongest correlation with treatment effectiveness when clients received relatively few sessions, it is important to foster client emotional states and develop a relationship where there are mutual feelings of closeness and affection as this is likely to be important for successful therapy (Saunders, 1999).

As was suggested above, it is quite possible that therapists are more able to form positive growth promoting relationships with some clients than with others. For some time research has focussed on the aspects of client distress levels before therapy and of client pre therapy interpersonal relations. If relational elements such as those associated with the therapeutic bond are more strongly associated with specific client variables then it is necessary to consider these as potential moderators of relational processes. For example, Blatt, Ford et al (1994) have suggested that clients who are more willing to explore and be open about difficulties in interpersonal relationships are more likely to make substantial treatment gains. In addition to this, others have suggested that the quality of a client’s internal object relations are associated with outcome. It is theorised that the better quality of internal object relations as defined by relational maturity the
more likely it is to achieve greater therapeutic change (Piper, Joyce, Azim & Rosie 1994).

Saunders (2001) has suggested that empathic resonance is related to poor outcome when high pre-therapy ratings of client detachment within interpersonal relationships were reported. This was the finding from a study with one hundred and forty one clients from a psychotherapy service who were surveyed on a single occasion. Clients provided data on a range of outcome measures and the therapeutic bond scales for TSR-Revised (Saunders 1999). Mutual affirmation was significantly correlated ($P < 0.05$) with self esteem and greater demoralization suggesting that clients who commenced therapy with low self esteem and less motivation experienced the relationship with their therapists as less mutually respectful. Additionally, clients who experienced greater empathic resonance, meaning they felt understood and understood their therapist, were shown to have significantly ($P < 0.05$) lower pretherapy levels of detachment in interpersonal relationships. However, whilst initially significant after correction using the Bonferroni test significance was lost ($P < 0.06$). It would appear from this evidence that there is growing support for the view of the therapeutic relationship as bi-directional and co-constructed. It could be suggested that increased levels of client and therapist attunement for one another together with a mutual respect and affirmation for one another are moderately associated with positive outcomes.

The bi-directional nature of the therapeutic relationship and the way client and therapist feel towards one another has been researched when considering the matching of positive and negative feelings for one another. Qualitative and naturalistic studies have started to look at the client processes influencing the effects of therapist interventions and the therapeutic support available. For example, a small number of research studies
have indicated that clients hold back negative feeling (Hill 1989) and they can do this out of deference for their therapist (Rennie 1985). Thompson and Hill (1991) used a system for matching client reactions to therapist interventions and the findings suggested that when therapists matched on certain reaction clusters, session impact was affected. For instance, when therapists matched client responses to the ‘therapeutic work’ cluster of reactions both clients and therapists perceived subsequent interventions as more helpful. In contrast when therapists matched client reactions as negative reactions or no reaction, both clients and therapists gave lower ratings for subsequent interventions. The authors suggest that therapists can be encouraged and motivated by perceptions of specific reactions from clients to their interventions.

The finding of matching therapeutic intervention leading to higher helpfulness ratings was not, however, replicated in a later study (Hill, Thompson & Corbett, 1992). An important finding that was replicated across these two studies was that lower helpfulness ratings were followed by therapist non-matching of client negative reactions than matching negative reactions. This suggests that when therapists are aware of client negative responses within therapy this may have a deleterious effect on therapist behaviour and session outcome. This finding is an important one for the present study as it appears to be suggesting that when therapists may perceive they are doing well yet this is not matched by client’s perception of the therapy then progress is poor. It could be argued from this qualitative research that outcome is likely to be better when both client and therapist feel and perceive one another as feeling positive about their relationship.

Continuing the line of enquiry into client and therapist attunement to one another Regan and Hill (1992) reported that clients often left things unsaid in therapy sessions which had an impact on session outcome. Using client reports of sessions following each of six
sessions of brief therapy, clients and therapists reported thoughts or feelings of things that were left unsaid. Therapists tended to avoid revealing emotions and clinical conjectures whereas clients did not reveal cognitions/behaviours and emotions. For both clients and therapists the majority of what was left unsaid was negative. Following this, therapists tried to identify what clients had decided not to reveal yet were only able to manage a seventeen percent success rate in this. However, importantly when therapists accurately identified that clients were reacting negatively within a session, these sessions were rated as less smooth by therapists and with less satisfaction by clients. Regan and Hill (1992) suggest that therapist and client perception of negative reactions by clients may impact on their behaviour which in turn may lead to a negative perception of the therapist and the session by the client. This again is an important finding for the present study which aims to explore the nature of mutuality within the therapeutic relationship. Here it seems that when there are perceived negative feelings from the client that the therapist is aware of this have a significant effect on therapist and client satisfaction with the therapy. It is likely that such feelings would in turn be reciprocated as client and therapist struggle to stay in relationship with one another.

This suggestion seems to have been supported in the findings of yet another study looking at client and therapist interpersonal perceptions. In this study client’s and therapist’s ratings of the perception of implicit processes in the other were obtained and were shown to have an impact on outcome. Hill, Thompson, Cogar and Denman III (1993) used client and therapist ratings of their own and others’ covert processes in therapy sessions. Interestingly, when clients were able to match therapist intentions of assessment both client and therapist rating of subsequent interventions were lower, suggesting that clients’ awareness of being assessed and therapists’ own awareness of the client’s experience of this appears to negatively affect session satisfaction. One
explanation given for this by the authors is that therapists sense this negative reaction of the client and behave less helpfully. This suggests that clients perceive being assessed negatively and when this is happening their awareness and understanding of the therapist may actually hinder therapeutic progress. However, in contrast to this when clients matched therapist intentions of exploration and restructuring, therapist rating of their next intervention as helpful was higher. Client rating of helpfulness was not, however, affected by this matching. These finding suggest that therapists have a more positive experience of the therapeutic session when they perceive the client as having a positive reaction to their efforts of support for the client. However, it is worth noting that this did not affect client views of the quality of the session.

5.4.2.3 Summary
The research reviewed in this section suggests that a reciprocal pattern to the unfolding nature of the empathic process within the therapeutic relationship is a better approximation than a unilateral perspective. This view suggests rather than a unilateral dose of therapist empathy being delivered to the client, empathy within the therapeutic relationship develops through reciprocity. Importantly, it appears that when therapists and clients similarly experience one another within the therapeutic relationship, or are able to match these views in the other, then progress is better. This last finding has particular significance for the present study as the arguments are being created for the therapeutic effect of mutuality.
5.4.3. Unconditional positive regard: evidence for bidirectional process
Again using the work of Orlinsky, Ronnestad and Willutzki (2004) in the generic model of psychotherapy it is possible to draw links from research into a range of process variable that have some overlap with the Rogerian hypothesis. For example, the term 'affective environment' has been used to refer to the feelings of the therapist and client towards one another. Under this comes both therapist and client positive regard for one another which has often alternatively been referred to as warmth or respect. Orlinsky, Ronnestad and Willutzki (2004) within the generic model of psychotherapy position this component under the therapeutic bond and has received much attention from researchers over the years (Orlinsky & Howard, 1986; 1994). Within the generic model of psychotherapy over one hundred and fifty four findings from a total of seventy five studies have been reviewed providing a strong body of evidence for this element of the therapeutic relationship. Positive results are especially apparent when client ratings of therapist affirmation are used in association with outcome. The latest review shows forty one from sixty three findings showing a positive association, two were negative and twenty null findings. From the therapist rating perspective of therapist affirmation the results are slightly less convincing but remain promising with nineteen positive findings, nineteen null findings and only one negative finding.

5.4.3.1 Unconditional positive regard and mutual affirmation
The argument being generated in the present study is that the way that client and therapist feel towards one another or perceive the other feeling towards them is an important factor in generating positive outcome. As was shown above, a series of studies appeared to suggest that therapist perception of client negative feelings
adversely affected the outcome of therapy. In this section, further evidence used to explore this element in relation to mutual affirmation (Orlinsky, Ronnestad & Willutzki, 2004). Client affirmation towards the therapist has contributed a total of fifty seven findings from thirty six studies and has been rated from various perspectives with similar results from each. Of the twenty five findings showing client ratings sixteen (64%) cases had a positive association with outcome, eight (32%) were null findings with one negative finding. Client affirmation using therapist ratings was assessed in twenty two findings with fifteen (68%) positive findings and seven (32%) null findings and no negative findings. Finally, observer ratings of client affirmation were used in nine findings and positive association with outcome was obtained in seven (78%) with one null and one negative finding.

Orlinsky, Ronnestad and Willutzki (2004) have also reviewed the evidence for mutual affirmation between therapist and client within the therapeutic bond compiling the data from a total of twenty six studies. Mutual affirmation refers to the reciprocal affective patterns within the therapeutic relationship and can include both affirmation and negation. Client ratings of mutual affirmation once again provided robust evidence of this construct being associated with positive outcomes with eleven (73%) from fifteen studies showing positive results, only four (27%) null findings and no negative findings were obtained. The therapist rating perspective provided the least number of studies with only three presented in the review, of these one was positive and two were null findings. Independent observer ratings of mutual affirmation provide eleven findings in total with ten (91%) of these being positive findings, one null finding and no negative findings being reported.
5.4.3.2 Positive regard and therapist-client communicative process
A series of studies looking at the interactions and ways that positive and negative feeling are communicated and experienced between clients and therapists have been conducted. These studies suggest that the way therapists respond to their clients is affected by the way in which the client presents either themselves or their problem within therapeutic encounters. A series of early analogue studies using therapists from a range of therapeutic orientations that examined their responses to clients presented using either film or written statements was carried out (Strupp 1955a; 1955b; 1955c; 1958a; 1958b; 1958c) and showed that therapists responded more negatively towards ‘difficult’ client cases. Negative process within the therapeutic relationship appears to be a significant factor influencing psychotherapy outcomes (Binder and Strupp 1997). Binder and Strupp (1997), in reviewing a large body of empirical and theoretical literature, conclude that the therapeutic relationship is a bidirectional dyadic system in which client and therapist affect one another and therapist ability to manage negative process is an important factor in achieving positive outcome.

Exploring the interpersonal relational field through the use of micro analysis of specific therapist and client interaction has provided useful findings for understanding bi-directional flow of feelings and attitudes in the therapy (Henry, Schacht & Strupp, 1986; 1990). In line with the relational view of distress, the basic premise of this research is that clients introject the relational experience gained from the interpersonal and therapeutic relationship. The eventual aim is to produce change within the client’s interpersonal relations which are viewed as the source of the initial distress.

In psychodynamic-interpersonal therapies Henry et al (1986; 1990) found that cases which had a poor outcome were related to therapist and client interactions. These
interactions were characterised by therapists who were less likely to grant friendly autonomy to clients and who exhibited higher levels of hostile and controlling behaviour. In addition, clients who responded to therapists with less affiliative autonomy and had higher levels of hostile separation also showed poor outcomes. These results have been replicated more recently by Jørgensen et al (2000) who also found that higher levels of client hostile separation was associated with poor outcome. Critchfield, Henry, Castonguay and Borkovec (2007) have suggested that it would appear therapists can interact with clients in ways that can produce good or poor outcomes even while employing the same specific techniques. This point adds support to the argument that specific techniques play less of a role than relational factors.

Support for the structural analysis of social behaviour model suggested by Strupp et al (1986; 1990) was less convincing for a range of CBT based therapies. Using a similar methodology for coding therapist and client interactions, Critchfield et al (2007) used data from a previous study which compared three manual based CBT packages (Borkovec, Newman, Pincus, & Lytle, 2002) with a sample of clients being treated for generalised anxiety disorder. The authors reported that little support for the negative effects of hostility were found and that specific interpersonal behaviours were generally poor predictors in either good or poor outcome cases. This may in part be explained by the low levels of observed hostility reported by those responsible for rating in all three therapeutic approaches. Additionally, it is important to consider the possible effects of treatments being delivered using therapy manuals as these are specifically designed to minimise interpersonal variation on behalf of the therapist.

In support of a bi-directional view of the therapeutic relationship there is some evidence to suggest that when therapists and clients demonstrate affiliative behaviours in their
interactions with one another outcome is improved (Muran, Samstag, Jilton, Batchelder & Winston 1997). Using a method for coding client and therapist behaviour based on a circumplex model proposed by Wiggins (1982) clients and therapists were rated on their affiliative and controlling behaviour within interactions. The study by Muran et al (1997) adopted an approach similar to the one used by Henry, Schacht and Strupp (1986; 1990) but was aimed at developing a standardised measure and strategy for independent observers. In their analysis they found significant negative correlations showing medium effect sizes between ratings of both client and therapist hostility and outcome. This was found across the range of the length of the therapeutic course and especially in the early stages of therapy. Interestingly, these effect sizes remained in the moderate range when client and therapist scores for affiliative behaviours were placed on the circumplex model axis. To do this client and therapist scores for hostility and friendliness were subtracted from one another thus giving therapeutic dyads an absolute score of either positive or negative interaction. These were then related to overall outcome supporting the hypothesised findings in a number of cases that positive interaction within relationships was associated with better outcome.

The affective attitude between client and therapist can lead to ruptures within the alliance and subsequent working through of such ruptures can often prove to be significant with regards to change events (Safran 1993; Safran & Segal 1990; Safran & Muran 2000). As was noted above, clients are often hypothesised to internalise or introject therapist - client relational events and when these are positive they can be facilitative towards making constructive change. Client interpersonal style can be a potential challenge to constructive interpersonal relations. For example, the way in which therapists respond at critical points in the therapeutic encounter can open up and offer the client opportunities for exploration of key inter and intrapersonal processes that may
contribute to positive change. Likewise, therapists also have the potential to respond negatively in such situations and thus hinder therapeutic progress at critical points. One way in which situations can emerge is when client’s relational presence is challenging for the therapist and conflict emerges. Luborsky and Crits-Christoph (1998) have referred to this as when a client’s core conflictual relational theme (CCRT) has been presented within a session.

Sommerfield, Orbach, Zim and Mikulincer (2008) tested the Luborsky and Crits-Christoph (1998) hypothesis using a content analysis of one hundred and fifty one sessions taken from five different therapeutic relationships. Ruptures in the alliance concerning confrontation were associated with the presence and emergence of client’s CCRT when the therapist was addressed as the significant other. Interestingly, there was a significant negative correlation between the level of CCRT speech about romantic partners and confrontation of alliance ruptures. When clients rated sessions where ruptures had occurred they were viewed as less smooth than sessions without ruptures. These findings lend some support to the argument that client and therapist interaction that captures the positive and or negative attitudes is related to outcome. However, as with other such studies no causal inference between CCRT and session outcome or CCRT and alliance rupture can be assumed based on correlated data collected at a single point in time.

In another study that considered CCRT and explored the affective environment of the therapeutic relationship from a bi-directional perspective reciprocal and compensatory client and therapist interactions were analysed. Anstadt, Merten, Ullrich and Krause (1997) looked at CCRTs and related these to outcome with clients receiving fifteen sessions of either psychoanalytic, cognitive behavioural or client centred therapy. The
authors found that when therapists reciprocated client affect by their facial expression this was a poor predictor of outcome. Compensation on the other hand was found to be a better predictor of outcome across the range of therapeutic approaches. It is worth noting however, that reciprocity of affect in this study was related to and equated with therapists matching client affect for happiness which was proposed to be a defence pattern of both client and therapist. Likewise, reciprocated negative affect was considered more helpful as indicative of being in a risky area however, it was considered to be limited in effectiveness and not as effective as compensating facial expression. This study applied psychoanalytic theory (CCRT) to a range of therapeutic interventions and showed that similar relational and affective patterns emerge across therapies. However, the sample size of eleven is small and therefore it is hard to make broad generalisations. On the other hand, it is clear again that it is necessary to consider the therapeutic relationship as a bi-directional process no matter which therapeutic approach one is oriented towards.

A study which considered the amount of trust a client has in their therapist and the association with the degree of therapeutic conditions that are perceived was carried out by Peschken and Johnson (1997). This study used the Barrett-Lennard (1962) Relationship Inventory to measure the levels of client and therapist perceived therapeutic conditions in a small sample of forty eight clients and their therapists. Both clients and therapist also completed the Dyadic Trust Scale (DTS; Larzelere & Huston, 1980) and clients completed the Brief Symptom Inventory (Derogatis, 1992). Significant correlations were obtained between client own rating of the B-L RI and the DTS as were therapists. However, there were no significant correlations across client and therapist ratings of the B-L RI or DTS measures suggesting that clients and therapists often have different views of the therapeutic relationship. However, using the four subscales of the
B-L RI to look at correlations between individual subscales and trust found that therapist rating of congruence and empathy was significantly positively correlated with client rating of therapist trust. Likewise, client rating of therapist congruence was significantly positively correlated with the level of trust clients had in their therapist.

5.4.3.3 Summary
It would appear from the research reviewed in this section that a relatively robust body of literature exists in favour of the association of unconditional positive regard and outcome. In addition to this, there seems to be a relatively significant amount of evidence which is overlapping with the alliance field. This evidence is predominantly from the areas of the therapeutic bond and mutual affirmation constructs. As a result of this, it can be said with some degree of confidence that the client’s affective attitude towards therapist is most likely shaped somewhat by their own pre-therapy personality, level of distress and motivation for therapy. Together with this, the evidence above seems to suggest that these client variables are likely to play a significant role in the extent to which clients receive the therapist’s provision of the therapeutic conditions necessary for establishing a positive therapeutic bond with the client.

5.4.4 Congruence: evidence for bidirectional process
In the most recent review of the process outcome research using the guidance of the generic psychotherapy model, Orlinsky, Rønnestad and Willutzki (2004) suggested that self relatedness can be considered to have three main component areas for research. These are client positive self relatedness, client negative self relatedness and therapist
self relatedness. Client positive self relatedness refers to genuineness, experiencing, acceptance of feelings, felt autonomy, defence maturity and modelled self care (internalising the therapeutic relationship). Client negative self relatedness refers to defensive inhibition and self consciousness. Therapist self relatedness refers specifically to genuineness, countertransference management and self-critical reflectivity, all of which are tied into the notion of congruence.

5.4.4.1 Congruence and Self relatedness
Self relatedness in the generic model of psychotherapy refers to the internal states of the participants within the psychotherapy relationship during sessions. From a client-centred perspective the notion of self relatedness overlaps with the Rogerian notion of congruence. Typically, research carried out assessing the person-centred notion of therapist congruence has been concerned with the association between the level of client perceived therapist congruence and positive outcome. Additionally, therapist congruence has been assessed from the therapist’s and independent observer’s perspective. However, when considering genuineness in other approaches it is client genuineness that has been most frequently focussed on in research studies. For example, a number of studies have considered this variable in clients who receive psychodynamic interpersonal therapy (Ablon & Jones 1999; Eugster & Wampold 1996). In addition to this, one recent study that has focussed on the client perspective and considered the related topic of client ‘experiencing’, a term generally considered a part of experiential therapy, focussed on the process of cognitive behavioural therapy (Castonguay et al 1996).
Orlinsky, Rønnestad and Willutzki (2004) review presents the findings of over one hundred and fifty studies. Interestingly, client genuineness has been viewed as a promising variable yet only five studies were recorded between 1992 and 2002 two of which have not been published in English, of the three that have they each show promising results. Kolden (1996) carried out a study to explore the effect of client openness and therapeutic bond on change during the early phase of dynamic psychotherapy. Openness was measured based on the client’s openness to experience, psychological availability, awareness of moment-to-moment thoughts and feelings, being receptive to others and is without distortion in experience. It is clear from these constructs there is some overlap with the Rogerian notion of congruence. In this study outcome was assessed using a range of measures covering therapeutic realisations and session progress. Clients reported on their own perception of their openness, therapeutic bond and realisations using the TSR after the third session. Openness and bond were both found to predict therapeutic realisations and bond and realisations both significantly contributed to variance in outcome using the session progress as the target outcome measure.

Eugster and Wampold (1996) collected data from one hundred and nineteen clients receiving therapeutic treatments from one hundred and fourteen therapists working from a variety of theoretical orientations. This study measured client genuineness using items from the Barrett-Lennard Relationship Inventory embedded within an eighty item process measure developed for the purpose of the study. The results of the study offer support for the finding that when the client perceives the therapist as being real then session progress was better. However, when therapists rated their level of genuineness and the real relationship they also rated session progress as being poor. Eugster and Wampold (1996) point out that despite the evidence collected from clients’ perceptions over many
years in favour of the humanity of the therapist, the authentic encounter leading to positive outcomes many therapists continue to stress the importance of technique over relationship.

Ablon and Jones (1999) used data collected in the NIMH TDCRP project which compared IPT and CBT for depression. In addition to the mutual acceptance between client and therapist noted in the argument above the researchers also reported that in both IPT and CBT therapy positive outcomes were characterised by an association with client openness to exploration and process and therapist genuineness. Client openness to experience was also noted in a study to explore the effects of specific and common factors in cognitive therapy for depression (Castonguay et al. 1996). In this study the authors tested the effect of client openness to experiencing emotional involvement, the therapeutic alliance and focus on distorted cognitions. The results indicated that when therapists continued to focus on distortion that emerged as a result of ruptures in the alliance, the strain worsened and thereby interfering with client change. On the other hand, clients who were more open to experiencing emotional involvement in the session and the therapeutic alliance both predicted outcome above the level of chance.

5.4.4.2 Summary
The section above has taken the unfamiliar position of considering congruence from both sides of the therapeutic dyad. The evidence for the association between therapist congruence and outcome is good but not as robust as it is for the other two therapeutic relationship conditions of empathy and UPR. However, this may in part be due to the difficulty in measuring a construct that refers to an internal state of the therapist. There are some interesting findings from those studies that have turned their attention to the
notion of client genuineness and openness. Indeed, one of these studies (Eugster & Wampold, 1996) used client’s ratings of their own genuineness using items from the congruence subscale of the B-L RI and found this to be associated with outcome. This is an innovative piece of research and has significant association with the approach adopted within the present study. The study in question was an early empirical attempt to measure the real relationship. The concept of the real relationship appears to provide potential for understanding the bi-directional nature of the therapeutic relationship. A closer examination of some recent relevant research into the real relationship follows.

5.4.5 The ‘real’ relationship
The present study is concerned with the way the therapeutic relationship is perceived by both client and therapist and how their views are related to outcome. As is apparent from the arguments developed so far it is helpful to consider the therapeutic relationship as a bi-directional process. It is clear from the research reviewed so far that there have been a number of attempts to explore the bi-directional processes within the therapeutic relationship. The therapeutic relationship is proposed to comprise several interacting elements (Gelso & Carter 1994). This includes the Rogerian relationship conditions, working alliance, transference - counter transference and what has been referred to as the real relationship. These elements conceptually overlap with one another yet each retains distinct contributory potential. Of these interrelated elements, this section considers the real relationship as this is potentially of interest to this study as it is closely aligned with the concept of mutual perceptions of empathy, positive regard and congruence.
The concept of the real relationship was first alluded to as a distinct and important element of the therapeutic context by Freud (1937) and later by his daughter Anna Freud (1954). In the field of psychoanalytic theory, until recently, Greenson (1967) has contributed most to the concept of the real relationship. However, in recent times Gelso (2009) has reviewed several contributions to the development of the concept and together with colleagues has refined the definition, advanced real relationship theory and developed a measure for use in empirical study (Gelso, 2002; Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998 Gelso et al 2005). In the sections below the overlap between the concept of the real relationship and the person-centred theory of the therapeutic relationship is considered.

5.4.5.1 Therapeutic conditions and the real relationship construct
Gelso (2009) defines the real relationship as “the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other” (p. 255). In this definition two main features are offered as making up the real relationship construct. The first is the construct genuineness and applies to both the therapist and client within the therapeutic dyad. This has been defined by Gelso (2002) as the “ability to be who one truly is, to be nonphoney, to be authentic in the here and now” (p. 37). This definition clearly aligns the meaning of genuineness as it pertains to real relationship theory as it does for Rogers (1959).

The second construct identified by Gelso et al (2005) is realism. Realism is defined as “the experiencing and perceiving of the other in ways that befit him or her, rather than as projections of wished for or feared other (i.e. transference)” (p. 37) (Gelso 2004). In
making the case for realism as a feature of the real relationship the following are offered by Gelso (2009) as non-real relationship experiences. In the first instance that the client perceived the therapist as not ‘real’, the client may say; “where are you coming from?” (p. 255) or make a statement such as “I just don’t think you have a clue who I am” (p. 255). These statements are interesting. If these are taken alongside the initial definition of realism and added to the experiencing and perceiving elements, the whole definition begins to take on a distinct similarity to the client centred use of empathic understanding put forward by Rogers (1959).

It should be noted that in addition to genuineness and realism, Gelso et al (2005) state that magnitude and valence of the real relationship are also important factors to be considered. Here, magnitude refers to the question of ‘how much’ genuineness and realness is possessed within a relationship. Valence, on the hand, refers to the positive and negative views of the relationship by both client and therapist. In this scheme, when there is a high magnitude of both genuineness and realism and is positively valenced then a strong real relationship is purported to exist. Gelso (2009) also suggests that the magnitude of the real relationship will increase following a linear course over the duration of therapy and that a higher positive valence to the relationship may be experienced at the beginning and ending of therapy.

Gelso (2009) has suggested that there is a need for empirical research into the concept of the real relationship. However, some have raised questions that need to be addressed if the potential for studying the real relationship is to be fulfilled. For example, McCullough (2009) raises doubts over whether the real relationship must be characterised by a positive valence in order for it to be facilitative. For instance, McCullough (2009) argues that there may be circumstances where the client feels
negative emotions towards the therapist and the relationship and that a healthy real relationship needs to be able to permit such expression and the potential for working through the conflicts. In addition, according to McCullough’s (2009) argument, in order to make a complete assessment of the real relationship it is necessary to distinguish between those conflicts that are not expressions of the negative transference and those that have been successfully worked through. Also, it is required to distinguish between conflicts, such as therapist errors, that have been worked through or remain unresolved.

Likewise, McCullough’s (2009) argument highlights the possibility that the real relationship is more important in short term therapy than long term therapy based on the premise that transference projections are identified and pointed out and contrasted with the real relationship as opposed to allowing a transference neurosis to develop over time in the two therapies respectively. However, in response Gelso (2009) has suggested that the role of the real relationship in long term therapy is also important as it may help the successful resolution of transference. Interestingly, McCullough (2009) states that in brief psychodynamic psychotherapy the term ‘real’ refers to an ‘egalitarian relationship of mutual respect’ (p. 265) which again has a strong resonance with the client-centred tradition of psychotherapy and the role played within the therapeutic relationship of unconditional positive regard.

5.4.5.2 Measuring the real relationship

Operationalizing and subsequently measuring the real relationship has proved problematic (Hatcher, 2009; Horvath, 2009; McCullough 2009). Despite the findings set out above from the Gelso et al study, it would appear that the two factor model of the
real relationship is not yet clearly defined. Using confirmatory factor analysis Gelso et al (2005) were unable to clearly identify genuineness and realism as two distinct factors.

An interesting aspect of the real relationship theory is the relation between this construct and the therapeutic alliance. Gelso et al (2005) reported that in a study to validate the Real Relationship Inventory- Therapist (RRI-T) tool the real relationship correlated with the alliance, when using the Working alliance Inventory (WAI-S) only moderately ($r = .47$). Gelso et al (2005) suggest that from this finding the working alliance and real relationship appear to be two related but different concepts. Additionally, the genuineness and realism subscales correlations with the WAI-S differed significantly, $t(89) = 5.13$, $p < .05$, with genuineness ($r = .55$) correlating more strongly than realism ($r = .32$). Coupled with this, the intercorrelation for the two subscales obtained in the validation study was reported as $r = .75$ and thus does not lend support for the two factor model.

Horvath (2009) points out that in contrast to the therapist measure, the client measure of the real relationship (RRI-C) developed by Gelso and colleagues correlates highly with the WAI-S (.79) and with the bond component (.81) particularly highly. From this it is apparent that clients find it difficult to discriminate between the two measures or that the two constructs are themselves not distinct from one another (Horvath 2009).

Based on the apparent difficulty in distinguishing between genuineness and realism and high overlap between the real relationship defined by Gelso and the therapeutic alliance, Horvath (2009) raises the question of whether it would be better to measure the real relationship using an established measure of genuineness. Here, Horvath (2009) suggests the Barrett-Lennard (1962) Relationship Inventory (B-L RI) congruence
subscale as it has already been widely used in empirical research and identified as showing promise as a relational factor associated with outcome (Norcross 2002). In addition to this, and in further support for using the B-L RI for addressing the real relationship, the concept of mutual respect has also been suggested to comprise a core element and worthy of exploration and inclusion in further investigation by both Horvath (2009) and McCullough (2009).

Fuertes et al (2007) carried out a study using both the therapist and client versions of the RRI. The study obtained correlations with a range of other measures including the empathy subscale of the B-LRI, WAI-S, experiences in close relationships scale (ECRS) (Brennan, Clark, and Shaver 1998), client attachment to therapist scale (CATS) (Mallinckrodt et al 1995) and the counselling outcome measure (COM) (Gelso and Johnson 1983). Therapist rating of the real relationship was significantly correlated with alliance (.50), significantly negatively correlated with attachment avoidance (-.35) and with progress (.36). Client rating of the real relationship was significantly correlated with client assessment of alliance (.71), secure attachment to therapist (.33), significantly negatively correlated with avoidance of attachment (-.64) and significantly positively correlated with client rated therapist empathy (.61) and client rated progress (.49).

These findings present some issues for Gelso’s concept of the real relationship as both client and therapist ratings of strong real relationships were lower when attachment avoidance was higher. Additionally, in the same study a hierarchical regression analysis was carried out that showed client rated empathy was significantly negatively related to client rated progress. This finding is the inverse to that found in the correlation reported earlier and was unexplained within the study as no suppressor variable was found in partial correlations using progress, alliance, attachment to therapist and real relationship.
This finding is an important one and highlights the difficulties in assessing the relationships between self reported variables at a single point in time of the therapeutic process.

Hatcher (2009) suggests that a problem with Gelso’s (2009) attempt to partition the therapeutic relationship into component parts is partly the problem found when operationalizing the real relationship. Hatcher (2009) suggests it is unnecessary to partition the therapeutic relationship in this way and the various components of the relationship become more apparent depending upon how we look at them. Similarly, the perspective from which they are observed is also a crucial element in identifying the different aspects of the relationship that may be in play. For example, Hatcher (2009) uses the example that a therapist may believe they are being empathic when the client perceives this as phoney. Such a mismatch in the perception of attitude would seem crucial to both the process effectiveness of therapist empathy and also as to how strongly therapist empathy is related to outcome. This point was picked up earlier in a previous section yet it is worth noting again since it appears the interplay of relational attitudes and qualities between therapist and client are of central importance. A mismatch between therapist perception in empathy for the client and the client experience of being understood may explain previous findings that show a low correlation between the relationship conditions and outcome. This explanation could be considered as an alternative to the two variables being only weakly related.

It would appear that the research carried out so far indicates that the real relationship is a construct worthy of further study and theoretical development. It can be argued that the realism element of this construct is strongly related to Rogers’ (1959) notion of empathic understanding based on the need for accurate perceiving and experiencing of
the other. In addition, the genuineness element is clearly intended to be the same as that suggested by Rogers (1959) and may be better measured by B-L RI. Finally, given the notion that the real relationship is lacking an element akin to unconditional positive regard, it is hard to see quite where this construct differs from the therapeutic relationship as it is conceived within the person-centred approach.

5.4.6 Summary: the therapeutic relationship as a bi-directional process
The research reviewed above has primarily focussed on the therapeutic relationship conditions of empathy, unconditional positive regard and congruence. In addition to this, evidence from the fields of research relevant to those elements of the alliance that overlap with these constructs. The argument has been made that the way that the therapeutic conditions operate within therapy is through bi-directional process. That is, the therapeutic relationship develops out of the reciprocity of empathic attunement, unconditional acceptance and congruence. This directly challenges the view that positive outcomes result from the unilateral provision of the therapeutic conditions from therapist to client, much in the way one might expect a drug to be administered to a patient.

The notion of such an outcome response to the dose of therapeutic conditions has been referred to as the drug metaphor (Stiles & Shapiro 1989). Stiles and Shapiro (1989) argued that the misconception of the various process variables being investigated as having a drug like effect on the client could account for the somewhat mixed findings from many process outcome research studies. For instance, Stiles and Shapiro (1989) suggest that process and outcome variables are not totally separate phenomena and that giving names to different components of the psychotherapy process creates the
impression that these are pure and measurable ingredients that lead to positive outcomes and that such ingredients can be found within therapist behaviour.

If the drug metaphor is an accurate metaphorical representation of psychotherapy then it would hold that the more a process variable is available the better the outcome should be and that the levels of process components ought to be correlated to outcomes across clients (Stiles & Shapiro 1994). However, this was not the case when correlations for several verbal process components with outcome were assessed using three different measures of symptom severity in a sample of thirty nine clients. The Stiles and Shapiro (1994) study found significant differences between the verbal response modes of cognitive behavioural therapists and psychodynamic interpersonal therapists across all five response modes, however, correlations of these with outcome measures were non-significant.

However, Stiles and Shapiro (1994) do not suggest that process variables are inert within the therapeutic process. Rather, these findings are proposed to be the result of flawed logic. The authors state that high quality human interaction, as one would expect to find in psychotherapy, is interactive and systematically responsive (Elliott 1984; Elliott et al 1982). If this is so, it is to be expected that well attuned psychotherapy practitioners of all orientations are providing such process variables in quantities that reflect the changing needs of clients, perhaps even on a moment by moment basis. Such a strong critique of the correlation design of process outcome variables raises questions about the effectiveness of this method. However, Stiles and Shapiro (1994) suggest that the methodological difficulties lie in the assumption of a linear relationship between process and outcome variables. Instead they propose that what is needed is a consideration of the way that process variables, say for example client perception of therapist empathy, is
affected by a range of other variables such as client resistance or therapist responsiveness.

It would appear then that the relationship between therapists provided conditions and outcome is not a logical linear relationship. Rather, therapists and clients contribute to the therapeutic process through the interaction of mutually embedded components (Russell, Jones & Miller 2007). In addition to this suggestion, the findings have highlighted the potential reciprocity in relationships between a range of process variables and process variables and outcome. For example, there have been a large number of recent additions to the therapeutic relationship literature that have considered the contribution of the therapeutic alliance to outcome (Beutler, Malik, Alimohamed et al, 2004; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000; and Stevens, Hynan & Allen, 2000). However, of particular relevance to this study from the alliance field are the contributions of alliance research into the therapeutic bond. This element, together with self relatedness, is listed under the Generic Model of Psychotherapy (Orlinsky & Howard 1986) as comprising the interpersonal aspects of the psychotherapy process. In breaking these concepts down further the present study is concerned with particular elements within the bond and self relatedness literature. For example, of particular interest are the points summarized in the process aspects of the generic model for the bond as the social and emotional aspects that are reflected in the expressive attunement of client and therapist and their affective attitudes towards one another; and for self relatedness the concern is with the manner in which client and therapist are receptive and open to one another (Orlinsky, Ronnestad & Willutzki, 2004). The following section explores the recent literature concerning the therapeutic bond and self relatedness.
5.5 Mutuality and the association with well being through close personal relationships and social support

5.5.1 Mutuality in close personal relationships

Barker and Pistrang (2002) have suggested there is a great deal that both the psychotherapy and social support literature have in common and that each can learn from one another. Perceived available social support in close personal relationships is now generally accepted as being associated as having a positive effect on psychological well being (Lindorff, 2000; Sarason, Sarason & Gunrung, 2001). Empathy in social support has been shown to be an important element of successful helping by Pistrang, Picciotto and Barker (2001) especially when this was rated as a mutual experience. In addition, Pistrang, Barker and Rutter (1997) suggested that low mutual understanding and empathy between close couple partners was the main cause for dissatisfaction in helping when discussing a range of topics related to breast cancer. However, social support is not ubiquitous in its positive effects, especially when considering the effects of received support. For example, some researchers suggest that received support has only a neutral effect (Bolger, Foster, Vinokur, & Ng 1996) and others have suggested that receiving support can even have negative effects on well being (Bolger, Zuckerman, & Kessler 2000). One explanation of the apparent neutral or negative effect of receiving support has been suggested by Gleason, Iida, Bolger, and Shrout (2003) who hypothesised that negative effects could be ‘offset by reciprocation of support, that is, by creating a sense of supportive equity’ (Gleason, Iida, Bolger, & Shrout, 2003 pp. 1036 italics added).
In Gleason, Iida, Bolger and Shrout (2003) participating partner couples were asked to complete daily records of mood and of received and provided emotional support. Their results suggest that reciprocity of support was associated with higher levels of positive mood and lower levels of negative mood. In addition and in support of previous findings receiving support that was not reciprocated was associated with increased negative mood whereas giving support was associated with a decrease in negative mood regardless of the level of support received.

In a similar study the effects of daily supportive exchanges of social support in couples when one partner within the couple was affected by multiple sclerosis (MS), Kleiboer, Kuijer and Hox et al (2006) used a diary study to explore the degree of equity in receiving and providing emotional and instrumental support on well being. The study required sixty one MS patients and their partners to complete diaries at the end of each day rating their mood, self esteem the degree of received and provided emotional and instrumental support together with rating their daily hassles as a control variable. The results suggested that reciprocity in instrumental support was associated with higher levels of self esteem within both patients and partners. Interestingly, patients well being was associated with providing both emotional support and instrumental support, whereas partners’ well being was related to receiving emotional support from patients (Kleiboer, Kuijer & Hox et al 2006). With the exception of the positive effect of reciprocity of instrumental support on self esteem, this study failed to support the findings of Gleason, Iida, Bolger, and Shrout, (2003) and no supporting evidence for the suggestion that equity in emotional support for partners with illnesses was found. However, the authors note that the study did not account for the possibility that some couples recorded inequity of support yet did not perceive there to be an inequity. The role of reciprocity of emotional support in those experiencing illness may have a different function, however.
In some situations it has been argued that a ‘need-based’ rule for providing support applies and that equity has less importance (Clark & Mills 1979). These findings have tended to regard mutuality as simply reflecting the amount of support that is provided and reciprocated. However, as we have noted above mutuality involves possibly more than the simple equitable transaction of quantitative measures of support.

Taking the understanding of mutuality suggested in the ‘self-in-relation’ model (Surrey 1993), there has been interest in the effect of mutuality within close personal relationships on both physical and mental well being. Interestingly, couples’ relationships have typically been understood from the perspective that they are a source of stress as opposed to being a source of strength (Kasle, Wilhelm & Zautra 2008). Kasle, Wilhelm and Zautral (2008) explored the physical and psychological health outcomes of married/partnered patients experiencing rheumatoid arthritis in relation to their perceptions of self mutuality, partner mutuality and overall mutuality. The findings suggested that overall mutuality (combined responsiveness) and partner mutuality (perception of partners responsiveness) predicted fewer symptoms of depression for both men and women but self mutuality (perception of own responsiveness) was more important for women than for men. The role of mutuality in close couple relationships was also shown to be associated with lower levels of depression and less suppression of negative emotions such as anger in women (Sperberg & Stabb 1998). Likewise, in a study examining the connection between perceived mutuality and quality of relationships together with well being, women were shown to associate their perception of mutuality with marital satisfaction, self esteem and less depression (Lippes 1999).

Mutuality in close personal relationships has been shown to be an important factor when considering the effect on psychological well being and eating behaviour. Tantillo and
Sanftner (2003) carried out a study to assess the relationship between perceived mutuality and bulimic symptoms, depression, and therapeutic change. Following random assignment to either short term group CBT or Relational Therapy the results showed that both therapeutic approaches were effective in lowering depression, improving binge eating and reducing vomiting at the end of treatment and at follow up assessment times. Additionally, base line measures indicating low levels of perceived mutuality within their relationship with father were associated with high levels of bulimic and depressive symptoms across assessment times and low levels of perceived mutuality with mother were associated with high levels of depression.

Sanftner, Tantillo and Seidlitz (2004) explored the association between perceived mutuality in relationships with partners and friends and eating disorders in a group of seventy four women thirty five of whom had a diagnosed eating disorder and thirty nine acted as controls. Lower levels of perceived mutuality as assessed using the Mutual Psychological Development Questionnaire (MPDQ) (Genero, Miller & Surrey 1992) were reported by the eating disorder group for both partners and friends and the negative aspects of perceived mutuality were shown to be particularly important in differentiating the two groups. This suggests that a lack of relational connection may be particularly important to understanding the development of eating disorders. However, depression accounted for much of the variance in the level of perceived mutuality in relationships with partners although this was not the case for friends where the result remained significance.

Again, in using a measure of mutuality taken from data collected within a college population using the MPDQ Sanftner, Cameron, Tantillo et al (2006) hypothesised that perceived mutuality would predict scores on the Eating Disorder Inventory- 2 scale after
controlling for other family variables such as expressed emotion. The results showed that perceived mutuality was associated with eating disorder symptoms and behaviours including when the variance accounted for by expressed emotion was factored out. The main criticism and problem with each of these studies that has explored the association between perceived mutuality in close personal relationships and eating disorders is that they collect data on perceived mutuality at a single point in time and with a person outside of the therapeutic relationship. As a result we are not able to infer any causal association between the levels of perceived mutuality and eating disorder nor that the perception of mutuality between client and therapist which is important in producing growth.

Mutuality between parent-child interactions has been a significant feature in the development of relational theories. Such theories suggest that parent-child mutuality is comprised of emotional reciprocity, co-responsiveness and cooperation (Deater-Deckard & Petrill 2004). In a study looking at the effects of parent-child dyadic mutuality Deater-Deckard and Petrill (2004) explored the effects of mutuality within parent-child dyads for adoptive and genetically related dyads within and between families. Using recordings from videotaped interactions mutuality was measured using a composite score of ratings of responsiveness, interaction reciprocity, and cooperation. Higher levels of perceived mutuality were shown to be related to lower levels of child behaviour problems. The results also suggested that mutuality is child specific within families but that this is not related to whether the child was an adoptive or genetically related to the parent. This finding supports the notion of a bi-directional parent-child effect in socialisation. If correct, this finding may be important to psychotherapy as it is possible that greater levels of mutuality may be achieved dependent upon the therapist-client dyad and their potential compatibility.
Other fields that have explored the role mutuality on outcomes within interpersonal relationships include career counselling (Felsman & Blustein, 1999), peer mentoring (Spencer & Rhodes 2005) and manager-employee relations (Dabos & Rousseau 2004). Felsman and Blustein (1999) measured attachment to peers, intimacy and mutuality to determine the association with environmental and self exploration and progress in committing to career choices. Using data collected from one hundred and forty seven participants significant correlations were found for all three predictor variables with mutuality being significantly associated with vocational exploration and commitment but not with self exploration. In line with relational theories this suggests that those who experience mutuality in their close personal relationships are supported in making adaptive developmental transitions (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991).

An interesting perspective on the role of mutuality and reciprocity has been put forward by Dabos and Rousseau (2004) who studied the effects within manager and employee relations. In this context perceived mutuality was defined by the extent of agreement between the parties over specific terms within the psychological contract (Rousseau 1995) and reciprocity as the degree of reciprocal contribution made by each party under the specific terms of the psychological contract (Rousseau 2001a). By looking at data collected from eighty employee-employer dyads within sixteen separate university research centres it was found that both mutuality and reciprocity were associated with a range of outcomes including those associated with satisfaction, career advancement and commitment to the employing organization.
5.5.2 Summary
The findings reviewed above suggest that mutuality has a broad range of applications within a host of relational contexts and not only those confined to the counselling and psychotherapy situation. It would appear that, in social relationships, perceived mutuality is considered to be the extent to which there is a degree of equity in a range of aspects of the specific relationship. These include; co-responsiveness, co-understanding, co-operation, authenticity and co-acceptance plus some suggestion of equity of exchange. Many of these are relevant to the field of counselling and psychotherapy, however, psychotherapy is not a normal social relationship and there are clear differences in terms of roles and the power that exists within those roles. For this reason it is necessary to understand what mutuality means within the context of the psychotherapeutic encounter.

5.6 Setting the research question and summary of aims for the present study
The findings reviewed above suggest that mutuality has a broad range of applications within a host of relational contexts and not only those confined to the counselling and psychotherapy situation. It would appear that, in social relationships, perceived mutuality is considered to be the extent to which there is a degree of equity in a range of aspects of the specific relationship. These include, co-responsiveness, co-understanding, co-operation, authenticity and co-acceptance plus some suggestion of equity of exchange. Many of these are relevant to the field of counselling and psychotherapy, however, psychotherapy is not a normal social relationship and there are clear differences in terms of roles and the power that exists within those roles. For this reason it is necessary to understand what mutuality means within the context of the psychotherapeutic encounter.
It is generally accepted that the core conditions are relevant to all psychotherapy approaches and the evidence reviewed above supports this view. For example, typically the way in which the core conditions have been conceptualised as being operational within the psychotherapy encounter has been as a unilateral phenomenon.

The present study addresses the following primary research question
- Do client and therapist mutually provide the therapeutic conditions of empathic understanding, unconditional positive regard and congruence and to what extent are these related to outcome in psychotherapy?

There is a need to consider bi-directional processes in the way the core conditions are measured especially when considering their association to outcome. In addressing the research question the following hypotheses will be tested in the present study:

**Hypothesis one**
- The psychotherapy observed within this study will be effective as indicated by client rating of CORE-OM showing reliable and clinically significant improvement

**Hypothesis two**
- Positive psychological adjustment, indicated by decreasing scores in the CORE-OM, will be significantly negatively correlated with perceived levels of therapeutic relationship conditions indicated by high scores on the B-L RI.
This will be the case when the therapeutic relationship conditions are measured from the following perspectives:

- The client’s view of the therapist provided conditions
- The therapist’s view of the therapist provided conditions
- The client’s view of the client provided conditions
- The therapist’s view of the client provided conditions

**Hypothesis three**

- When clients and therapists perceive mutually high levels of the therapeutic conditions being provided by the therapist, the association between the client rating of therapist provided conditions and outcome will be strongest.

**Hypothesis four**

- When clients and therapists perceive mutually high levels of therapeutic conditions being provided by each other then the association between client rating of therapist provided conditions and outcome will be strongest.
Part 3: Method and results

Chapter 6

Method
6.1 Design
The study is a non experimental longitudinal naturalistic design to test the association between the therapeutic relationship and psychotherapy outcome. In addition to this, the more specific aim was to determine a measure of mutuality and to test whether an association could be established between mutually high levels of the therapeutic relationship conditions and psychotherapy outcome. As a result, a number of variables were measured. The primary dependent variable was psychotherapy outcome and was assessed using a self report measure. The primary outcome measurement tool used was the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM). CORE-OM is a non-specific measure of psychological distress. The independent variables were the level of empathy, unconditional positive regard and congruence that were experienced by clients and therapists. This was assessed from the extent to which both clients and therapists perceived the other to be offering the therapeutic conditions and also their own rating of the levels of therapeutic conditions they were themselves offering to the other. Put more simply, the independent variables were assessed by measuring the level of each therapeutic condition as they were perceived from the vantage point of myself to other (MO) and other to self (OS) for both client and therapist. This was done using a shortened version of the revised Barrett-Lennard (1964) Relationship Inventory (B-L RI). It was intended that the data be collected following the first, third and where possible fifth session of individual psychotherapy that was carried out in two U.K. University counselling centres (DeMontfort University and Bath Spa University), a workplace counselling service (BT Staff Counselling service), a counselling and psychotherapy centre from the voluntary sector (Derby Women’s Centre) and from
private practice. Outcome data and relationship questionnaires were completed simultaneously between December 2006 and January 2009.

6.2 Ethical Considerations
This research was carried within the British Psychological Society (BPS) Code of Ethics (BPS, 2006) which stipulates the principles to be observed when carrying out or conducting research. The proposal for the study was passed by the Loughborough University Ethics Committee on the August 7th 2006.

6.2.1 Informed Consent
Each client who was invited to be a participant in the study was initially informed that the study was designed to be an exploration of the way in which a therapist and client get along with one another and how this relationship affects the outcome of therapy. All participant therapists had likewise been instructed to inform interested clients that the research was concerned with an exploration of the quality of the therapeutic relationship and any associated benefits for clients. A standard information leaflet (See Appendix 1) which had further details on the topic of the study was given to all clients. The leaflet explained the process of the research protocol providing clear details of the requirement for participating clients to complete questionnaires, the occasions when this would be required and the number of occasions on which this would be required.

The information leaflet also explained that participants maintained the right to withdraw from the study at any time without the need to give a reason to their therapist or the researcher for their withdrawal. Participants were given the opportunity to ask any remaining questions they believed were required or to clarify any points of confusion if
they were unsure on any particular issue. A pilot case had suggested that due to the appearance of the B-L RI form it may not be clear to participants they were required to complete both sides of the forms. It was believed that this may cause confusion and lead to significantly increased levels of incomplete data. To manage this situation each time a session ended the participant was reminded to complete both sides of the form. Participants were not given any incentives to be involved in the study. Finally, the detachable back page of the information leaflet which contained a statement of informed consent was signed and returned to the therapist and in turn the therapist returned this form to the researcher.

6.2.2 Confidentiality
The detachable informed consent form also contained a section to gather demographic data for each participant. This section was coded to match their response sheets and in order to maintain confidentiality was subsequently stored separately from the questionnaire response forms. During the data collection process the questionnaire response forms were completed by participants and were then placed in an envelope which had their client case reference number written in the top corner. The client case reference number was assigned by the service where the client was accessing therapy. This provided an assurance of continuity in data management and matching the correct demographic data with client questionnaire response forms.

In those cases where the therapy took place in private or independent practice, the therapist was asked to allocate the client a case number if this was not part of their usual practice. When the envelope was returned to the therapist it was stored within the case file for that particular participant. Therapist participants also completed their
questionnaire forms and placed these in envelopes with their initials signed at the top. On completion of a full data set, or if therapy was terminated before the data set was complete, the researcher was contacted and the envelopes were collected from the participating service or independent practitioner. In cases where the participating service or therapist were situated in a geographical location too far to collect the envelopes in person, the data was sent by recorded delivery. When the data had been collected it was stored in a secure location. Therapist participants were identifiable to the researcher only and when the data was entered onto SPSS each therapist was given a code so they could not be identified. These measures ensured that confidentiality of responses was managed effectively and ethically throughout the study.

6.2.3 Clinical Governance
Procedures were required to manage the possible ethical issue regarding the protection of participants. This issue concerned the potential deterioration of participant psychological well being during therapy. As the researcher was gaining access to the progress or deterioration of participants during psychotherapy, the possibility of harm to participants needed to be considered. The ethical issue was whether or not the researcher should intervene if the data showed significant deterioration in client distress. However, given that in the majority of cases the researcher did not have access to the data until after the therapy had been completed, or that it was at least some time after the data was collected, and that change in therapy rarely tends to be linear in progress, it was decided that the researcher would take no action in cases where there appeared to be deterioration.
Supporting this decision is the point that the therapist, clinical supervisor and service manager have clinical responsibility for the client and not the researcher. In addition, given that the data collected for the study was relevant to the first three sessions it is likely that a number of participants may report higher levels of distress after therapy had commenced as the difficulties being addressed became the centre of the participant’s attention. It was decided that deterioration is an unfortunate yet well know consequence of receiving psychotherapy for some participants.

6.2.4 Debriefing
On completion of the study participants were asked by their therapist if they had any questions. There had been no deception involved in recruiting the participants so there was no requirement to inform participants of any aspect of the study which had been hidden from them. Participants were again reminded of the email address of the researcher if they felt they needed to ask questions in the future. Participants were also told that they could access a copy of the summary of findings from the study if they wished to by emailing the researcher.

6.3 Participants
There are two categories of participant in the study. The first are client participants who had self referred to one of the counselling and psychotherapy centres taking part in the study. Second were counsellors and psychotherapists working within one of the centres involved in the study or participating as an independent therapist. During the data collection period ninety one clients showed an initial interest in taking part in the study. Out of these, seventy six clients agreed to complete the necessary forms at the end of
session one. Two sets of forms were spoiled and two did not return the forms at the end of the session. Of the remaining seventy two clients, one client returned the form for outcome data but failed to return the B-L RI. Of the remaining seventy one clients sixty five completed forms a second time at session three as five clients terminated therapy before session three and one client who continued yet did not complete any subsequent forms for the B-L RI. Of the sixty five clients that reached session three and completed all forms, thirty eight clients continued in therapy until session five. Only thirty five of these clients completed further sets of the outcome measure and B-L RI forms. Twenty therapists showed an initial interest and responded to an advertisement placed in a the British Association for Counselling and Psychotherapy (BACP) Association for University and College Counselling (AUCC) publication and twelve agreed to take part in the study. Details of therapist participants are set out in the section below.

6.3.1 Client participants attending first session
The demographic data collected showed that of the seventy two client participants that completed and returned forms following session one, fifty six (78%) were women and sixteen (22%) were men. The mean age of clients was 26 years. Fifty seven of the clients taking part in the study (79.2%) were white, two (2.8%) were Asian, one client was (1.4%) Black, two (2.8%) were Chinese and four (5.6%) stated other as their ethnic origin with six clients (8.3%) not returning data. Of the sixty nine clients who provided a response to a question enquiring about taking antidepressant medication nine responded that they were taking medication at the time of commencing therapy and sixty said they were not taking any antidepressants. Of the nine clients who said they were taking medication one was male and eight were female.
Clients who returned forms for session one were either receiving therapy through an educational institution (N=60), a work based counselling scheme (N=1), a charitable counselling/psychotherapy service (N=10) or independent private practice (N=1). All participants were told about the aims and objectives of the study by giving them an information leaflet and all had the opportunity for discussion about the study before they volunteered to take part.

Table 6.1 Demographic details for client participants attending first, third and fifth session.

<table>
<thead>
<tr>
<th></th>
<th>Session 1</th>
<th>Session 3</th>
<th>Session 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
</tr>
<tr>
<td></td>
<td>(N=72)</td>
<td>(%)</td>
<td>(N=65)</td>
</tr>
<tr>
<td>Sex male</td>
<td>16</td>
<td>22.2</td>
<td>15</td>
</tr>
<tr>
<td>Sex female</td>
<td>56</td>
<td>77.8</td>
<td>50</td>
</tr>
<tr>
<td>Age 18-35</td>
<td>62</td>
<td>86.1</td>
<td>55</td>
</tr>
<tr>
<td>Age 36-50</td>
<td>8</td>
<td>11.1</td>
<td>8</td>
</tr>
<tr>
<td>Age 51 and over</td>
<td>2</td>
<td>2.8</td>
<td>2</td>
</tr>
<tr>
<td>Ethnicity white</td>
<td>57</td>
<td>79.2</td>
<td>55</td>
</tr>
<tr>
<td>Ethnicity asian</td>
<td>2</td>
<td>2.8</td>
<td>1</td>
</tr>
<tr>
<td>Ethnicity black</td>
<td>1</td>
<td>1.4</td>
<td>1</td>
</tr>
<tr>
<td>Ethnicity chinese</td>
<td>2</td>
<td>2.8</td>
<td>2</td>
</tr>
<tr>
<td>Ethnicity other</td>
<td>4</td>
<td>5.6</td>
<td>4</td>
</tr>
<tr>
<td>Antidepressant yes</td>
<td>9</td>
<td>12.5</td>
<td>9</td>
</tr>
<tr>
<td>Antidepressant no</td>
<td>60</td>
<td>83.3</td>
<td>53</td>
</tr>
</tbody>
</table>
6.3.1.1 Client participants attending third session
Of the seventy two clients that completed data at session one, sixty five continued to complete forms after three sessions of therapy. The demographic data for this group is shown in the second column in Table 6.1 above. There were missing data from three clients who did not record ethnicity and two clients who did not respond to the question asking about medication.

6.3.1.2 Client participants attending fifth session
Of the sixty five participants who completed three sessions of therapy a total of thirty five completed five sessions of therapy. The demographic details for this group are also shown in the third column in Table 6.1 above. One client failed to return data for ethnicity and two clients did not respond to the question about their use of antidepressant medication.

6.3.2 Therapist participants
There were a total of twelve therapist participants who took part in the study. Nine were female and three were male. Five therapists were still in training with at least one years experience and provided data during their clinical practice placements, two had recently qualified and four were experienced therapists with between five and eighteen years post qualifying experience. Five of the trainee and two experienced therapists identified themselves as person-centred, one experienced therapist identified as using cognitive-behaviour therapy, and one as a solution focussed brief therapist, two further trainees identified themselves as integrative therapists and one as a Gestalt therapist.
Table 6.2 Demographic data for therapist participants.

<table>
<thead>
<tr>
<th>Therapist Code</th>
<th>Male/Female</th>
<th>Approach</th>
<th>Experience</th>
<th>No. of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>Person Centred</td>
<td>2yrs</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>Person Centred</td>
<td>15yrs</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>SFBT</td>
<td>18yrs</td>
<td>19</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>Person Centred</td>
<td>6yrs</td>
<td>28</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>Integrative</td>
<td>1yr</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Integrative</td>
<td>2yrs</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>Person Centred</td>
<td>2yrs</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>Gestalt</td>
<td>1 yr</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>Person Centred</td>
<td>1yr</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>Person Centred</td>
<td>1yr</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>CBT</td>
<td>7yrs</td>
<td>12</td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>Person Centred</td>
<td>1yr</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6.2 above shows the demographic details for the therapist participants and the number of clients seen by each therapist within the study.

6.4 Measures
All participants completed a demographic sheet which was attached to the informed consent and data protection sheet. The outcome questionnaires and relationship questionnaires were completed by clients; therapists completed only the relationship
questionnaires. Questionnaires were completed in the same order at each time of data collection as listed below.

6.4.1 Clinical Outcome in Routine Evaluation Measure (CORE-OM)
Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) (Barkham, Evans, Margison, McGrath, Mellor-Clark, Milne and Connell 1998) was used to assess pre and post levels of psychological distress. There were several reasons why this measure was selected to assess outcome in the present study. First, there has been wide spread reported use of the measure in published practice based outcome studies, the number of which that has steadily grown in the UK in recent years. In addition, and as a result of the growing popularity, benchmarking data for the CORE-OM is available. This enables researchers to compare the levels of reported severity of distress for the client population within individual studies with the average level of severity of distress for clients receiving psychotherapy in UK primary care services. Using the available benchmark data can enable comparisons to be made between levels of severity for the current study with a much wider body of published literature.

The CORE-OM is a 34-item self report measure that can be used as a pre, interim and post therapy outcome measure. Participants are asked to complete the measure based on how they have felt “over the last week”. The CORE-OM consists of high and low intensity items in three areas; subjective well being (4 items, e.g. “I have felt like crying”), problems (12 items, e.g. “I have felt tense, anxious or nervous”) and functioning (12 items, e.g. “I have felt able to cope when things go wrong”). In addition the measure also assesses a fourth factor risk to self and other (6 items, e.g. “I have thought of hurting myself” or “I have been physically violent to others”). The CORE-OM uses a five point
Likert scale ranging from 0 – 4 and is made up of positively and negatively worded questions. Responses range from “Not at all” to “Only Occasionally” to “Sometimes” to “Often” and “Most or all of the time”.

The psychometric properties of the CORE-OM show that it correlates highly with the BDI (.85) and has high internal consistency of 0.75 to 0.94 with one week test retest reliabilities of .60 to .91 (Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark & Audin 2002). Despite the four distinct areas listed above the underlying factor structure of the CORE-OM is reportedly complex (Lyne, Barrett, Evans & Barkham, 2006). The well-being, functioning and problems/symptoms subscales all being highly correlated with one another. A recent study proposed that these three subscales could be used as a general measure of psychological distress and risk could be used as a second scale (Lyne, Barrett, Evans & Barkham, 2006). However, when the measure is used as a general measure of distress the risk items can also act as an indicator of the overall distress being experienced by a client. Based on the inconclusive findings of the above study together with the wider body of literature regarding benchmarking data the current study used a composite mean score for the four original subscales subjective well being, problems/symptoms, functioning and risk.

6.4.2 Level of distress
The general level of distress experienced by the client participants was assessed using the CORE-OM. The early benchmark data for the CORE-OM suggest that a mean score above 1.10 for men and 1.29 for women indicates the clinical score for a cut-off point between a clinical population and a sample drawn from the general population (Mullin, Barkham, Mothersole, Bewick & Kinder, 2006). More recently it has been suggested that
the cut-off points can be rounded off and lowered given that a much larger clinical sample has since become available. Taking an aggregated sample \((n=10761)\) from previous research studies a slightly lower mean cut-off score of 0.99 was obtained when compared with a general population sample (Connell, Barkham, Stiles, Twigg, Singleton, Evans & Miles, 2007).

The current study adopted the later recommended adjusted mean cut-off score of 1.0 on the basis that the lower cut score has been derived from a much larger clinical sample and is therefore more representative of a clinical population. Despite this, the lower score will remain appropriate for use with the sample of clients in this study many of whom were functioning at a relatively high level. This can be assumed as many participants demonstrated their continued functioning through involvement in full time higher education whilst receiving psychotherapy. This decision for adopting the lower cut-off point is also supported by the finding that university students who attend counselling and psychotherapy services show levels of distress only marginally lower than age matched sample of young people presenting in primary care (Connell, Barkham & Mellor-Clark, 2007). The marginally lower levels of distress were found on the functioning/relationship levels and levels of symptoms/problems and risk was found to have no significant differences.

6.4.3 Clinical and Reliable Change
Given the wide diversity and range of presenting problems experienced by clients in the present study and the different service locations to which they presented for therapy, it was expected that the levels of psychological distress that clients would have been experiencing at the point of presentation to therapy would be varied. This posed a
challenge in determining when and to what extent the therapy has been deemed as successful. Additionally, to test the extent of the relationship between the therapeutic relationship and outcome it is important to know if the relationship is a factor in producing clinical and reliable change in participants. For example, there is some evidence to suggest that more significantly distressed clients take longer to recover and are less likely to improve (Kopta, Howard, Lowry & Beutler 1994).

Indeed, Rogers (1967) found this in the sample of clients taking part in the Wisconsin Study that looked at the effectiveness of client-centred therapy for schizophrenia. In this study the most severely distressed clients tended to change less over the course of the therapy and outcomes were poorer on a range of measures. Thus, for the therapy observed in this study to be classed as helpful it is important to use a method for assessing change that is both meaningful for the individual client as well as for comparing a group of clients with another matched group. It could be argued there is little reason in providing therapy if it is not effective. However, in the present climate of evidenced based practice measuring effectiveness and the degree of change required for that change to have been experienced as meaningful by the client is also essential. One method for considering the level of severity in distress and the extent to which distress is alleviated is through the use of a measure of clinically significant and reliable change.

6.4.3.1 Clinically Significant Change
Prior to the early 1980s change in psychotherapy had been measured through traditional significance testing methods. This meant that only change within groups of clients taking part in studies could be measured by testing the group means for pre and post outcome measure scores. Jacobson, Follette and Ravenstorf (1984) stated that change in therapy
"is clinically significant when the client moves from the dysfunctional to the functional range during the course of therapy." Jacobson and Truax (1991) gave three ways in which this process may be put into action, they are:

1. The level of functioning subsequent to therapy should fall outside the range of the dysfunctional population, where range is defined as within two standard deviations beyond (in the direction of functionality) the mean for that population.
2. The level of functioning subsequent to therapy should fall within the range of the functional or normal population, where range is defined as within two standard deviations of the mean of that population.
3. The level of functioning subsequent to therapy places that client closer to the mean of the functional population than it does to the mean of the dysfunctional population.

The method for determining meaningful clinical change under these criteria suggests that there are two distinct populations, which can provide both the functional and the dysfunctional distributions. There are, however, some problems with the concept of distinct distributions in that it may not be realistic to expect people to be able to move from the dysfunctional to functional distributions in some circumstances. An example of this may be those who are the most severely distressed in-patients in a psychiatric setting. It is unlikely that these individuals will be able to achieve the degree of change necessary to move from the dysfunctional into the functional distribution. This does not mean though that they are unable to change and that this change could nevertheless be personally meaningful and have a profound and significant impact towards improving their quality of life and sense of well being.
Likewise, it may be the case that the distributions of the dysfunctional and functional populations are not always overlapping. When this is the case it is more difficult to determine whether the change has been meaningful and can therefore be said to have been the result of psychotherapy. For instance, in some cases it may be possible for the distributions to overlap to such an extent that a score may have moved beyond the cut off point described above in example 2 as compared to examples 1 and 3. So that this change can be said to have been caused by some other factor than chance, Jacobson et al (1984) provided a formula for computing a reliable change index. This method provides a scheme for assessing when client change is both clinically significant and statistically reliable.

There are some basic difficulties with this method, for instance, normal distributions are assumed in both the functional and dysfunctional samples. The notion of a dysfunctional and functional distribution was challenged by Wampold and Jenson (1986) who suggest it is unlikely that two distinct distributions may exist in some samples. They proposed the notion that a single distribution curve would be a more accurate representation of the population and that the dysfunctional population is gathered at one end of the curve for that particular population. Another alternative to using distinct populations is to have a continuum from dysfunctional to functional at either end.

As the primary outcome measure in the current study is the CORE-OM it is important to determine how clinical and reliable change will be assessed. The index for assessing reliable and clinically significant change can be calculated for the CORE-OM using the method proposed by Jacobson et al (1984). As stated above the clinical cut-off score for using the CORE-OM is rounded to a mean of 1 and reliable change has been calculated as ± 0.48 (Evans, Margison & Barkham, 1998). This means that for a client to achieve
reliable and clinically significant change the mean pre therapy score must be above 1.0 and must be taken below this cut-off point whilst at the same time being reduced by at least 0.48.

6.4.4 Barrett-Lennard Relationship Inventory (B-LRI)
Items from the Barrett-Lennard Relationship Inventory (B-LRI) (Barrett-Lennard 1962/1964) were used to measure the quality of the relationship between client and therapist. A number of versions of the B-LRI exist that assess the perceived levels of therapeutic conditions from a range of vantage points. In the present study, client and therapist participants completed the B-LRI from both *myself-to-other* and *other-to-self* vantage points.

A review of the internal reliability of the revised and original B-LRI has found that the mean internal reliability coefficients for the four subscales are; empathy, .84; regard, .91; unconditionality of regard, .74; congruence, .88. Test-retest reliability also shows stable results with mean test-retest correlations of empathy, .83; regard, .83; unconditionality of regard, .80; congruence, .85 (Gurman 1977).

6.4.4.1 Item selection
For the purpose of this study it was necessary to reduce the number of items used in the B-L RI, since both clients and therapists were required to complete the form from two vantage points on each occasion. This presented the difficulty of identifying the specific items to be included in the forms used in the study. A number of factor analyses of the B-LRI have been carried out which have provided some support for the four factor model originally proposed (Cramer, 1986; Lietaer, 1974; Walker and Little, 1969). The results of
these analyses have shown that, although some overlap does exist, it is unusual for the same items to repeatedly load highly on the four factors. This suggested that using a random sample of the items may be the most appropriate method of selection. However, a totally random approach would not account for the specific equal balance in the revised version given to positive and negatively worded items. To maintain this balance a different solution was required.

The rationale in reducing the number of items used was to lessen the burden placed upon participants and so increase the likelihood of participation and completion. It was decided to reduce the revised 64-item B-LRI to a shortened 32-item version. The 32 items were selected by taking every other item from each of the four subscales in the revised version of the B-LRI.

Interestingly, of the fifteen items reported by Lietaer (1974) and also identified in the Cramer (1986) study as highly loading, this method yielded ten overlapping items of those used in the present study. In addition to this, one further item overlapped with the 23 items which overlapped in the Cramer (1986) and the Walker and Little (1969) studies. Also some overlapped with the Lietaer (1974) results, meaning that a total of eleven items from the thirty two item measure were overlapping and had previously loaded heavily in one of the earlier factor analytic studies cited above. Three of these items were taken from the level of regard subscale (items numbered; 16, 26, 46 on revised 64-item B-LRI), three from the Empathy subscale (items numbered; 22, 42, 67 on revised 64-item B-LRI), four from Unconditionality (items numbered; 8, 48, 63, 68 on revised 64-item B-LRI) and one from the congruence subscale (44 on revised 64-item B-LRI). The resulting 32-item scale consisted of eight items from each of the four subscales which helped preserve the overall structure of the B-LRI and an equal number of
positively and negatively worded items for each of the four subscales/factors had also been retained.

A further modification was required and involved slight adjustment to the wording of questions in order to remove potentially sexist language. The question structure of the B-LRI has been modified for use in different settings. For example, Cramer (1986) modified the revised 64-item other to self version to be answerable by either female or male relationships by providing both female and male pronouns. However, the British Psychological Society (BPS) division of Counselling Psychology conference submission requirements (2007) suggested that usage of such pronouns may appear sexist. They recommended the preferred terminology which is the use of ‘they’ as opposed to ‘he/she’.

For this study, all male and female pronouns were changed to incorporate and use the BPS preferred stylised terminology.

6.4.4.2 Scoring the B-LRI

The level of relationship conditions was scored using a composite measure of the total score for the 32-item version of the B-LRI. The scale itself is made up of questions that relate specifically to empathy, level of regard, unconditionality of regard and congruence. These were operationalised by Barrett-Lennard (1962) and based on Rogers’ (1957/1959) theory of the necessary and sufficient therapeutic conditions. The definitions used and provided by Barrett-Lennard (1962) are set out below.

The empathy items within the B-LRI

Barrett-Lennard (1962) defined the condition of empathy for the construction of the B-LRI as:
“the extent to which one person is conscious of the immediate awareness of another… it is an active process of desiring to know the full present and changing awareness of another person, of reaching out to receive his communication and meaning, and of translating his words and signs into experienced meaning that matches at least those aspects of his awareness that are most important to him at that moment. It is an experiencing of the consciousness ‘behind’ another’s outward communication.” (Barrett-Lennard, 1962, p.3)

This definition reflects the three modes of empathy highlighted and described by Bohart, Elliott, Greenberg and Watson (2002) as, empathic rapport, communicative attunement and person empathy. Bohart et al (2002) state that these three modes are in no way mutually exclusive and are often differentiated only by a matter of emphasis. In this study, it was expected that therapists would most likely be emphasising communicative attunement and person empathy whilst clients were more likely to be emphasising empathic rapport. Barrett-Lennard’s (1962) definition of empathy works well for the receiving of and the need for client empathy with the therapist. For example, Barrett-Lennard (1962) suggests taking the ‘words and signs’ and ‘translating’ them into ‘experienced meaning’ and experiencing the ‘consciousness behind another’s outward communication’ suggesting the need for attunement to the other person in a present way.

Barrett-Lennard (1981) later emphasised a cyclical model of empathy and noted the client had a place in being the ‘receiver’ of empathy. Barkham (1988) suggested that this important and neglected component of the empathic process is all too often not an observed phenomenon in psychotherapy research. The current study accounts for this by measuring client empathy for the therapist. Examples of empathy items for the Other to
Self version are: “They usually understand the whole of what I mean” or “They usually sense or realise what I am feeling”. The example for the Myself to Other version is the same but with self referent wordings (e.g. “I usually sense or realise what they are feeling”).

The level of regard items within the B-LRI

Barrett-Lennard (1962) defined the level of regard and is paraphrased as;

“The affective aspect of one person’s response to another…. Positive feelings include respect, liking, appreciation, affection, and any other affectively adient response…. Negative feelings include dislike, impatience, contempt and in general affectively ambient responses. Level of regard… may be considered the composite loading of all the distinguishable feeling reactions of one person toward another, positive and negative, on a single abstract dimension. The lower extreme… represents “maximum predominance and intensity of negative type feeling, not merely a lack of positive feeling. (Barrett-Lennard 1962, p. 9)

Later Barrett-Lennard (2002) acknowledges that this definition does not reach to the farthest points of negative feeling such as hating, loathing or experiencing extreme fear of the other person. Similarly he points out that the extreme positive feelings that are associated with romantic, filial or spiritual love are not mentioned. However, he reports that he has yet to see any scores that are at the very bottom end of the scale and that only very occasionally is the most positive score given to all of the items.

Examples of level of regard items for the Other to Self version are; “They are truly interested in me” or “They are friendly and warm with me”. The same examples for the Myself to Other version are the same but with self referent wordings.
The unconditionality of regard items within the B-LRI

Having deconstructed Rogers’ therapeutic condition of unconditional positive regard, Barrett-Lennard (1962) provides the following understanding of unconditionality in addition to that of the level of regard above. Unconditionality of regard refers to:

“how little or much variability there is in one person’s responses to another (regardless of its general level)… the more A’s immediate regard for B varies in response to change in B’s feelings towards himself or toward A, or the different experiences or attitudes that B is communicating to A, or differences in A’s mood that are not dependent on B…the more conditional it is.” (Barrett-Lennard 1962, p. 4)

There has been some debate as to whether the two distinct aspects of regard and unconditionality of regard need to be assessed individually. Gurman (1977) performed a review of nine studies and found that such distinction was indeed justified. Examples of unconditionality items for the Other to Self version are: “Sometimes I am more worthwhile in their eyes than I am at other times” or “They want me to be a particular kind of person”. The same examples for the Myself to Other version are the same but with self referent wordings.

The congruence items within the B-LRI

Congruence – refers to

“the degree to which one person is functionally integrated in the context of his relationship with another, such that there is an absence of conflict or inconsistency between his total experience, his awareness, and his
overt communication… the highly congruent individual is completely honest, direct, and sincere in what he conveys, but he does not feel any compulsion to communicate his perceptions, or any need to withhold them for emotionally self protective reasons.”

Barrett- Lennard goes on to add,

“Direct evidence of lack of congruence includes, for example, inconsistency between what the individual says, and what he implies by expression, gestures or tone of voice. Indications of discomfort, tension, or anxiety are considered to be less direct but equally important evidence of lack of congruence.” (Barrett-Lennard 1962, p4)

In a later review of the B-LRI Barrett-Lennard (2002) simplifies this definition in saying that congruence, “implies consistency between the three levels of (i) a person’s primary, pre verbal or ‘gut’ experience, (ii) their inner symbolic consciousness and (iii) their outward behaviour and communication. Examples of congruence items for the Other to Self version are; “They express their true impressions and feelings with me” or “They are openly themselves in our relationship”. The same examples for the Myself to Other version are the same but with self referent wordings.

6.5 Procedure
A substantial degree of time and commitment was required for participating in the present study and recruitment was difficult to achieve. This was mainly due to practitioners not feeling as though they could ask clients to complete forms on a regular basis across the early course of therapy. However, a number of services did show initial interest. Data was collected from a range of counselling and psychotherapy settings which included two
university counselling centres (DeMontfort University and Bath Spa University), a
counselling and psychotherapy service from the voluntary sector in Derby (Derby
Women’s Centre), a workplace counselling service (BT Staff Counselling Service), an
Age Concern counselling service (Harmony Counselling Service) and from a small
number of independent/private practitioners. Further details of the services are given
below.

6.5.1 Recruitment of participating services
DeMontfort University Counselling Service
The service is situated within the wider Student Services Department and provides short
term counselling and psychotherapy for students of the university. Each student is able to
access the service free of charge and may receive up to 12 sessions in any one
presentation to the service. Students are seen on a self referral basis although university
lecturers and GP’s from the university medical centre often refer clients to the service.
The counselling service was staffed by a core therapy team consisting of three full time
therapists and one term time only therapist. There were three further therapists on
fractional contracts that amounted to an additional one and a half days per week term
time only. The service also offers placements to qualified counsellors seeking additional
hours in working towards accreditation by their accrediting body.

DeMontfort University Counselling Service had been involved in other research studies
including a study to compare the severity of distress that clients using university
counselling services may experience in comparison to those in primary care. Using data
made available from the Clinical Outcome in Routine Evaluation (CORE) Outcome
Measure national benchmarking data set there is evidence that those seeking
psychological therapy in university counselling services show a level of severity compared to that of those seen accessing psychological therapy in primary care settings (Connell, Barkham & Mellor-Clark 2007).

The University counselling service manager was approached by the researcher after receiving a response form an advert placed in the AUCC journal. The initial request to have the study implemented within the service was refused as the service was already involved in data collection for a different study. The following academic term the manager of the service agreed that data could be collected by the team of counsellors if they each individually wanted to contribute to data collection. A total of 5 counsellors agreed to take part and three actually collected data. Two were full time counsellors and one was the term time only counsellor. Within this service, the CORE-OM was already in use as an element of routine clinical practice as was the collection of demographic details. This meant that the only additional data to collect in this service was the B-LRI. The data in this study was collated by the researcher at the end of each completed contracted period of counselling.

_Bath Spa University Counselling Service_

The second university counselling service was recruited in response to an advert placed by the researcher in the AUCC journal a sub division of the British Association for Counselling and Psychotherapy (BACP). This university counselling service consisted of a single practitioner who collected data with clients who volunteered to take part in the study.

_Derby Women’s Centre_
The counselling and psychotherapy service located in Derby Women’s Centre was recruited through the researcher making telephone contact with the service and informing them of the study. Following this, the researcher was invited to speak to the counselling sub committee of the centre. After the sub committee had considered the study and decided to take part, the researcher attended an evening meeting of therapists and made a short presentation of the intended study. Therapists were invited to register their interest after this and the counselling service coordinator gave full support for the study. It was agreed at this meeting that the service would adopt the use of CORE-OM as a standard aspect of the clinical procedure of the service. Some therapists raised concerns about the collection of data on more than one occasion and questioned the need for this. The researcher proposed that as the data was being collected at the end of each therapy session no time would be lost in therapy for the client and this satisfied the therapists concerned.

*BT Staff Counselling Service*

One participating therapist working as part of an occupational health counselling service agreed to take part in the study.

*Age Concern*

Two participants from Age Concern were recruited through word of mouth of the study. Only one of these therapists provided data.
6.5.2 Recruitment of client participants
The recruitment of clients was standardised across the different therapeutic settings in which data was collected. At the point of first contact with the psychotherapy service or the first contact with an individual practitioner each client was made aware that the service was collecting data as part of a research study. The clients were informed that the study was concerned with the way in which the psychotherapist and client feel towards each other and how they perceive the other feels towards them and whether this can affect the overall outcome. Clients were then asked if they would be willing to take part in the study. For those who responded negatively the therapy or assessment continued from that point with no further mention of the study by the therapist. Clients who expressed an interest to know more about the study were given an information leaflet which outlined the study in more detail. On having read the leaflet the client was again asked if they agreed to take part in the study. All of the psychotherapists taking part had been instructed to inform clients that non-participation did not affect their entitlement to receive therapy. If clients agreed to take part, the therapy continued and the clients were handed out the CORE-OM and B-LRI forms at the end of the first session to take away and complete. For one of the university counselling centres, the CORE-OM was always completed by clients at the start of the first session as a standard aspect of the clinical practice of the service and so this measure was used in the study.

6.5.3 Data collection points
Data was collected at three points in time, the first, third and when possible the fifth session of therapy. The specific sessions selected for data collection were chosen for several reasons.
6.5.3.1 Session 1 CORE-OM
The CORE-OM was used to provide a baseline measure of psychological distress at the beginning of therapy. This was in order to enable the study to be integrated into one of the services that had agreed to participate in the study and was estimated to be the source of the greatest number of data sets.

6.5.3.2 Session 1 B-LRI
Barrett-Lennard (2002) (cited in Gurman (1977)) has estimated that approximately five sessions of psychotherapy were required for an adequate assessment of the relationship conditions to be made. Barrett-Lennard (2002) suggested that the therapeutic relationship is a process that emerges and unfolds over time. However, the estimate that five psychotherapy sessions are needed before the relationship will predict outcome seems to be anecdotal and there is little evidence in the psychotherapy literature that would appear to substantiate the claim.

In some circumstances, it is conceivable that first impressions in the initial psychotherapy session can shape the way clients, and to some extent therapists, develop attitudes and beliefs about each other. Indeed, if this is the case then it is also likely that this occurs very early on within the interpersonal interaction. On this basis, the very early encounter is crucial and it is possible that in a number of situations the first impressions of the therapist formed by the client may well determine whether or not the client returns for the second session. Zuroff and Blatt (2006) found that early levels of the therapeutic relationship assessed in the first psychotherapy session, were shown to be associated with levels of therapy completion. Therapy completion is in turn related to a more positive psychotherapy outcome. On this basis, the relationship data collected in session one was
considered to have been a reliable estimate of the initial impressions of the quality of the therapeutic relationship by both clients and therapists.

6.5.3.3 Session 3 CORE-OM
CORE-OM data was also collected in session three as evidence is accumulating that much of the reduction in clients’ symptom intensity during psychotherapy may occur suddenly (Hardy, Stiles, Cahill, Ispan, MacAskill & Barkham 2005). In addition to this, Ilardi and Craighead (1994) have suggested that the majority (60%-70%) of change in clinical trials takes place within the first 4 weeks of psychotherapy. Tang and DeRubeis (1999) indicated that early sudden gains can occur but stressed that this was only the case after cognitive changes had been noted in the pre-gain session. These findings were replicated in a later study by Hardy, Stiles, Cahill, Ispan, MacAskill and Barkham (2005) using practice from a real therapy session and not come from a clinical trial making the data more representative of everyday clinical practice.

In examining the validity of sudden gains noted by Tang and DeRubeis (1999), Vittengl, Clark and Jarrett (2005) found the sudden gains occurred with approximately the same moderate frequency in pill placebo and pharmacotherapy with clinical management as they did in the cognitive therapy condition. This raises questions about how change occurs and whether the proposed causes of change may be related to specific elements of a treatment approach or other non-specific factors. Regardless of what causal change processes may be at work in these studies Haas, Hill, Lambert and Morrell (2002) have shown that early and rapid changes in response to treatment (within the first 3 sessions) predicted final treatment status and follow up status, which suggests that early gains are important and are probably much more than
placebo. In a recent study by Zuroff and Blatt (2006) using data from the Treatment for Depression Collaborative Research Program study (TDCRP) found that even when early gains are controlled, the therapeutic relationship remained the strongest predictor of change.

On the basis of the above, and in addition to the need to gather as large a data set as possible, it was deemed methodologically sound to capture data relating to change that takes place early in the therapeutic process. This data is viewed as representative of later change and distal outcomes.

6.5.3.4 Session 3 B-LRI
Relationship data using the B-LRI was also collected by both client and therapist participants at the end of the third session. Much of the research which has investigated the association between the quality of the therapeutic relationship and psychotherapy outcome has used measures of the relationship at an earlier moment in the course of therapy and outcome at a later point in time. One of the main problems with this kind of research is that it does not account for changes that may be attributable to other variables such as age or psychological disturbance (Cramer & Takens 1992). The best way to reduce confounding by such variables is to randomly assign individuals to varying intensities of the independent variables. However, this is methodologically impossible when measuring relationship conditions and could even be viewed unethical (Cramer 1990a). Cramer (1990a) has suggested a possible alternative design for observing the association between the therapeutic relationship and outcome which can help alleviate this problem.
Panel design and analysis is a form of correlation study that can afford tentative suggestions to be made about the nature of the association between the independent and dependent variables. As a test for spuriousness panel analysis enables specified variables to be ruled out as being related to outcome and thus ruling them out as potential causal agents. Typically researchers have taken a measure of the quality of the therapeutic relationship at one point in time and measured the extent to which the quality of perceived relationship at the given point in time correlates with later or synchronous measurement of improvement/outcome. This has meant there has been no consistent time at which the therapeutic relationship has been measured across different studies which have assessed the strength of the correlation. In addition, this also means that the perceived quality of the therapeutic relationship may be rated as a result of the observed improvement rather than the other way around. Using panel analysis allows the quality of the therapeutic relationship and outcome to be measured on at least two separate occasions.

On this basis, it was deemed methodologically sound to collect data about the therapeutic relationship on more than one occasion. In addition to this, as is noted above, the therapeutic relationship is a concept that is likely to change over time and not remain static. Measuring the relationship at more than one point in time allowed for changes in the perception of the therapeutic relationship over time to be analysed.

6.5.3.5 Session 5 CORE-OM
A sub sample of the total sample completed 5 sessions of psychotherapy and the CORE-OM was also collected at the end of this session. Lambert and Ogles (2004) proposed that the rate of recovery is difficult to pin down and reviews have varied greatly in
estimating the precise number of sessions required to achieve clinical change which may depend to some extent on treatment approach and level of client disturbance at the time of commencing therapy. They suggest that a significant number of clients will have achieved clinical improvement within seven sessions, or even may be less. This provided a strong justification for measuring change over the first five sessions of psychotherapy.

Another reason to measure change early in the psychotherapy process is that psychotherapy drop out rates tend to be quite high with little known as to why this occurs. It may be that clients have achieved a satisfactory level of change and then do not attend a final session and complete outcome data. Again, it was viewed that collecting data at early stages would increase the likelihood that a maximum number of complete data sets would be obtained. Barkham, Connell and Stiles et al (2006) have shown that clients in routine practice settings achieve a ‘good enough’ level of improvement after a relatively small number of sessions. They examined data provided by 1472 clients who began treatment above clinical cut off with 88% of these clients having showed reliable and clinical improvement. Statistically the findings showed the rate of change as an aggregate negatively accelerating curve that may reflect a ‘dose effect relation’. That is, individual client’s end therapy at a point when they subjectively determine that they have reached a good enough level of improvement.

As the key service involved in data collection for the current study was able to provide service statistics which showed that clients, on average, ended after 4.5 sessions of therapy. The service was time limited to 12 sessions so once again five sessions was seen as being able to contribute a satisfactory number of clients to the study. However, other services were more open ended, yet one service (BT Staff Counselling) was time limited to six sessions.
Given the evidence reviewed above, and for the purpose of this study, it was viewed that change in psychotherapy occurs early in the therapeutic process and that a significant amount of change is probably going to have occurred within the first five sessions.
Chapter 7
Results
The effectiveness of psychotherapy.
7.1 Introduction
As part of the present study it was hypothesised that psychotherapy would be an effective method for producing lower levels of distress in clients who attended psychotherapy sessions. The first section of the results is concerned with establishing the overall effectiveness of the psychotherapy sessions observed within the study. Improvement was assessed using a self report outcome measure. CORE-OM was used as the generic measure for determining levels of psychological distress. It was intended that scores for the CORE-OM measure would be collected on at least two and where possible three separate occasions. However, this was not always possible as clients either did not remain in therapy until the third data collection point, and when they did, forms were sometimes not returned or were not fully completed. Additionally, clients were asked to complete relationship questionnaires at the same point in time as completing the outcome measure. On occasion, clients returned the outcome measure but did not return the relationship questionnaire that resulted in a number of incomplete data sets.

7.2 Establishing the treatment samples used for analysis
Managing missing data is an issue faced by all psychotherapy researchers. The result of an incomplete data set creates a difficulty for the researcher in determining which of the potential samples should be used for analysis. In this instance the following sets of data were available for analysis; the total intent to treat sample; those who reached the second data collection point and completed all forms after three sessions but did not go on to complete five sessions; those who reached the final data collection point after five sessions and completed all forms; and the total sample of those who reached the fifth session but did not return completed forms at that stage.
Attrition is an inevitable fact and forms part of the routine challenge of psychotherapy research study (Howard, Krause & Orlinsky 1986). How missing data is managed is an important aspect for any psychotherapy study and the method chosen will affect the final result in some way. Two possible ways of dealing with attrition in this study were identified. These involve either analysing only that data from those who complete the whole psychotherapy regimen as it was intended at the outset or analysing the data of the whole sample by using pre therapy scores as post therapy outcomes for those who did not complete the full course of therapy or did not return useable questionnaire forms (Kendall, Holmbeck & Verduin 2004).

Kendall, Holmbeck and Verduin (2004) suggest that the research context is a significant factor in determining how to manage missing data through attrition. For example, when managing the problem of attrition in carrying out randomised controlled trials, it is more likely to be of benefit to the research team to use the client’s pre therapy score as their end of therapy score as this provides the most conservative estimate of the outcomes and this requires the effect to be greater to achieve significant findings.

The present study had identified the first, third and fifth session as data collection points taken from routine psychotherapy practice. This suggests that the present study used specified end point data collection. One implication of using a sample derived from routine practice is that attrition is likely to be high. This may be for one of a number of reasons, for example, it is possible that clients will end therapy when it suits them as opposed to responding to the demand placed upon them to continue in therapy until the end of a research protocol. From the seventy six clients who agreed to take part in the current study, three clients dropped out before the third session, only thirty nine (54%) remained in therapy and provided data at session five and not all of these clients had
returned complete data sets. The actual number of clients that continued in therapy beyond the third session was higher than this; however, thirty nine is the number of clients that continued with therapy and also continued to provide the research data by returning the full range of necessary forms beyond session three.

From the sixty nine clients who attended at least three sessions, four clients failed to complete relationship questionnaires for the third session which left a sample of sixty five clients. Of these, three clients had not provided a session one CORE-OM score above clinical cut off and were deemed not to be sufficiently distressed for inclusion into the final study sample. This resulted in a sample of sixty two \((n = 62)\) clients, eighty six percent of the initial sample. Each of these clients had provided above clinical cut off scores on the CORE-OM in addition to completing full sets of the Barrett-Lennard Relationship Inventory. Each of these sets of data was matched with corresponding therapist completed versions of the B-LRI up to and including the third session point. This sample of sixty two clients was decided upon as the sample to use for data analysis. However, in order to do this it was necessary to compare the scores for those who completed questionnaires and returned data only as far as session three with those who continued to session five.

7.2.1 Comparability of session three and session five scores
In order to determine whether those clients who completed five sessions were significantly more or less distressed than those who attended for only three sessions it was important to explore the comparability of CORE-OM scores for these two groups within the total sample (Kendall, Holmbeck & Verduin 2004). Differences in scores for the CORE-OM in the first session and third session between the client groups who attended
up to session three and those who attended as far as session five were tested to determine whether either group was significantly more distressed than the other group at either point in time.

A one way analysis of variance was carried out to test for the difference between the scores for the CORE-OM for clients who received at least three sessions (group 1) of psychotherapy \( (n = 30, 48.4\%) \) and clients that continued with therapy and returned data until at least session five (group 2) \( (n = 32, 51.6\%) \). The results showed no significant differences \( (F = 0.000 \text{ and } p = 0.987) \) between the mean score for session one CORE-OM for those who attended for only three sessions (1.95) and for those who attended five sessions (1.96). Similar results were found at session three with no significant difference \( (F = 0.389 \text{ and } p = 0.535) \) in scores for the CORE-OM between the group completing just three sessions (1.38) and the group completing five sessions (1.49). Although the mean for those continuing for five sessions was slightly higher this difference was not significant.

As no significant differences in the levels of distress at session one or session three were observed it was decided that all subsequent analyses should be focussed on those who participated in the study and returned data up to session three as this yielded a much larger data set with which to carry out the analyses and provided greater power in the statistical tests to be carried out.

7.3 Measuring client improvement using session three CORE-OM
The principal outcome measure used in the present study was the CORE-OM. The CORE-OM data shows that on commencement of therapy the average client mean score
as 1.95 (n = 62, S.D. 0.55) and was significantly above the clinical cut-off point. At session three the results showed a group mean CORE-OM score of 1.43 (n = 62, S.D. 0.67) which remained above the clinical cut-off point. Of the sixty two clients who completed at least the first three sessions of psychotherapy fifty five (88.7 %) clients showed some improvement whilst seven (11.3%) clients showed deterioration.

7.3.1 Measuring clinical and reliable change between session one and session three CORE-OM
Both clinical and statistical significance are important in assessing the outcome of psychotherapy (Kendall, Holmbeck & Verdun 2004). Evans, Margison and Barkham (1998) developed a method for assessing reliable and clinically significant improvement (RCSI) for the CORE-OM. This method is based on the criteria suggested by Jacobson and Truax (1991) reliable change index and provides a means for calculating the change in client scores for the CORE-OM as clinically meaningful and statistically significant. This method requires that a client’s CORE-OM score must change by ± 0.48 in order to achieve reliable change. In addition to the reliable level of change, for clinically meaningful change to occur the score must also cross the point of clinical cut-off. Ultimately, to achieve clinically meaningful improvement a score must be reduced by at least 0.48 and must also change from being a clinical score, that is a mean score greater than or equal to 1.0, into the non clinical population achieving a mean score below the clinical cut-off point of 1.0 (see section 6.4.3 in Chapter 6 in the method section for a fuller discussion of this).

The data taken from the mean scores indicated that change in reported levels of distress on the CORE-OM between session one and session three satisfied the criteria for achieving reliable change. The mean score for the CORE-OM (n=62) decreased by
slightly more than 0.48 over the first three sessions. Whilst this change is reliable and is in the desired direction, the average for the whole sample did not move to below the cut off score of 1.0, suggesting that whilst on average clients achieved reliable change, they did not on average achieve clinical improvement in the first three sessions of therapy.

A shortcoming in using the data generated from the whole group is that only pre-post differences in the grand mean can be tested at the group level. At best this only provides a general picture of change. An advantage of using the reliable and clinical change index is being able to calculate reliable and clinically significant change for individual client scores rather than solely relying on the group mean scores. By definition, clients that commence therapy below the clinical cut off score are unable to achieve reliable and clinically significant improvement (Barkham, Connell, Stiles, Miles, et al 2006, Stiles, Barkham, Connell, & Mellor-Clark 2008).

The entire sample used in the analysis for the present study had commenced therapy above the clinical cut off. That is, each client had provided a mean CORE-OM score greater than or equal to 1.0 at session one. Of the total sample nineteen clients showed clinical change and moved from above to below the clinical cut off point. Of these, fifteen (24% of the total sample) had achieved reliable and clinically significant improvement and the remaining four (6.5% of the total sample) had achieved clinical improvement that was not reliable. A further thirty six (58% of the total sample) clients showed some improvement and only two clients (3% of the total sample) showed reliable deterioration. Of those that showed improvement fourteen clients (22.7%) showed reliable improvement. A further twenty seven (41.5%) showed change that was neither clinical nor reliable. Table 7.1 below shows the number and percentage of client change made.
The psychotherapy observed within this study proved to be effective with a total of thirty three clients (50.1%) who achieved at least some positive change and approximately a quarter of the whole sample showed reliable and clinically significant improvement within three sessions of psychotherapy.

Table 7.1 Reliable and clinically significant improvement between session one and three CORE-OM scores.

<table>
<thead>
<tr>
<th></th>
<th>RCSI Clinical improvement</th>
<th>Reliable improvement</th>
<th>Improvement neither clinical nor reliable</th>
<th>Deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1-3</td>
<td>Count</td>
<td>Row %</td>
<td>Count</td>
<td>Row %</td>
</tr>
<tr>
<td>Session 1-3</td>
<td>15</td>
<td>24.2</td>
<td>4</td>
<td>5.6</td>
</tr>
</tbody>
</table>

There were a small number of clients who showed clinical change that was not reliable and it could be suggested that these clients were moving in the right direction and would eventually reach the criteria for reliable and clinically significant improvement. Additionally, just under a quarter of the sample showed change that was not clinically meaningful but was reliable and just over a third of the sample showed improvement that was neither reliable nor clinically meaningful.

7.3.2 Effect sizes
Generally, it appears that clients in this study responded well to the therapy they received. Similar to previous findings within the psychotherapy outcome literature much of the observed improvement appeared to have occurred within relatively few sessions (Baldwin, Berkeljon, Atkins, Olsen & Nielson, 2009; Stiles, Barkham, Connell & Mellor-
Clark, 2008; Stiles, Leach, Barkham et al, 2003). The measure of clinical and reliable improvement is a useful measure for assessing individual change within the context of the sample population and for assessing the comparability of the group change compared to other similar samples. Another method for assessing the comparability of change across studies at the group level is to assess the overall effect size of the change that occurred within the study. This can allow for the size of effect in the current study to be compared with other studies.

The overall pre-post effect size for therapeutic change as measured by the CORE-OM over the first three sessions was calculated as the difference between the first and third session mean divided by the pooled standard deviation (Cohen’s  $d$). This produced an effect size for change in the CORE-OM between sessions one and three of 0.85 ($n = 62$). The effect size 0.85 for change during the first three sessions indicate a large effect during the first three sessions of psychotherapy.

7.3.3 Comparing outcomes across therapeutic approaches.
Support for the view that some approaches to psychotherapy are more effective than others has received significant attention (Gloaguen, Cottraux, Cucherat & Blackburn 1998). However, such superiority has been contested by researchers supporting an equivalence effect (Luborsky, Rosenthal, Diguer, Andrusyna, Berman, et al 2002) and those who propose a contextual model of psychotherapy (Wampold, Minami, Baskin & Tierney 2002). The current study used data derived from naturalistic therapy settings with a range of psychotherapy approaches being used. It is useful to test the effect in the current data set for the comparability in outcome that different approaches had. These
analyses will also be useful in informing and contextualising subsequent analyses that will test for the differential effect of the therapeutic relationship across the range of therapeutic approaches delivered in the present study.

7.3.3.1 Differential effectiveness of therapeutic approaches
The current study used practitioners from a range of psychotherapy models. Of the sixty two clients included in the analyses thirty two (51.6%) received person-centred therapy, fourteen (22.6%) received solution focussed brief therapy, eleven (17.7%) received cognitive behaviour therapy and five (8.1%) integrative/experiential therapy. A one way analysis of variance was used to test the mean scores for the CORE-OM on commencing therapy and again at session three across the four groups. The means and standard deviations for the different therapeutic approaches are presented in the table below.

<table>
<thead>
<tr>
<th>Therapeutic Approach</th>
<th>Session one</th>
<th></th>
<th>Session three</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>d</td>
</tr>
<tr>
<td>Person-centred</td>
<td>32</td>
<td>2.01</td>
<td>0.62</td>
<td>1.53</td>
<td>0.72</td>
<td>0.7</td>
</tr>
<tr>
<td>CBT</td>
<td>11</td>
<td>1.63</td>
<td>0.35</td>
<td>1.24</td>
<td>0.45</td>
<td>0.9</td>
</tr>
<tr>
<td>Solution Focussed Brief</td>
<td>14</td>
<td>2.09</td>
<td>0.39</td>
<td>1.43</td>
<td>0.78</td>
<td>1.1</td>
</tr>
<tr>
<td>Integrative/Experiential</td>
<td>5</td>
<td>1.63</td>
<td>0.42</td>
<td>1.27</td>
<td>0.48</td>
<td>0.79</td>
</tr>
<tr>
<td>Total</td>
<td>(62)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clients who received person-centred or solution focussed therapy were significantly \( F(2.675, p = 0.05, df 3) \) more distressed than those who received cognitive behaviour therapy or integrative/experiential therapy at session one. Interestingly this discrepancy
disappeared with no significant differences found in the one way ANOVA for CORE-OM scores across the different therapeutic approaches with clients in session three (F 0.600 p = 0.618, df 3).

7.3.3.2 Effect sizes for the different therapeutic approaches
The effect sizes for the four approaches were calculated using Cohens’s d displayed above in Table 7.2 and show solution focussed brief therapy produced the largest effect (1.1), followed by cognitive behaviour therapy (0.9), integrative/experiential (0.79) and person-centred therapy (0.7) having the same effect size. Interpretation of the size of the effects should be made with caution as the groups are not distributed evenly with regards to the number of clients each contributed to the analyses or the number of therapists making up the group. The person-centred group was made up of seven different therapists whereas the CBT and solution focussed brief therapy groups represent the effectiveness of a single therapist as each of these groups only had a single therapist contributing to the data and only contributed twelve and nineteen clients respectively.

7.3.4 Summary
There was a clinically significant and reliable improvement for about a quarter of the number of clients receiving therapy within this sample and in addition the total number of clients making reliable change was close to half the total sample. Looking at this in another way, two thirds of the clinical sample showed improvement that was either reliable but not clinical or clinical but not reliable. Given the short time frame over which data was collected this finding suggests that the psychotherapy in this study was effective. Many clients were moving in the direction towards a reduction in the level of distress and a longer period of therapy is likely to have increased the number of clients
achieving both reliable and clinically significant change. The study effect size of 0.85 is classed as a large effect and supports the findings that psychotherapy is effective.
Chapter 8

Results

An item factor analysis of a shortened Barrett-Lennard Relationship Inventory
8.1 Barrett-Lennard Relationship Inventory
The Barrett-Lennard (1962) Relationship Inventory (B-LRI) has been extensively used in studies exploring the effects of the therapeutic relationship in psychotherapy, the psychotherapy supervision relationship and in close personal relationships. The measure was used in this study as it is the most theoretically consistent with the therapeutic conditions proposed by Rogers as necessary and sufficient for therapeutic change to occur. The B-L RI measure is designed to assess the therapeutic variables from a number of vantage points including the client, therapist or independent observer perspective of the therapeutic relationship.

As discussed earlier in the method section (chapter 6, 6.4.4) the B-L RI consists of four separate subscales. In order to test whether the remaining analyses could explore the extent to which each of the four independent subscales related to outcome it was necessary to carry out an item factor analysis of the B-L RI with the data provided by the current study sample. If no clear four factor structure was obtained with the study sample it would be necessary to use a composite relationship score for exploring the role of the relationship in determining outcome.

The data collected for the B-L RI at session three was used for the purpose of the factor analyses. There are a number of reasons for this; first it was hypothesised that clients and therapists would have a greater chance of being able to answer the questions if they had met with one another on more than one occasion. This is based on the point that previous factor analyses (e.g. Cramer, 1996) have asked respondents to focus on relationships that they have been involved with for a substantial period of time prior to testing. It was assumed that a greater amount of time within the relationship would enable both members to have a better understanding of their experience of the other
person and thus increase the chances of identifying the underlying factors. Second, the third session had been identified as the point at which the data would be collected for final analyses and it was therefore necessary to have the relationship and outcome data collected simultaneously.

8.2 Factor analysis
The Barrett-Lennard (1962) Relationship Inventory was used to assess the levels of the therapeutic conditions of empathy, level of regard, un-conditionality of regard and congruence from the vantage points of ‘myself to other’ and ‘other to myself’ for both clients and therapists. There is some debate with regards to the underlying factor structure of the B-L RI (Cramer 1996) and no clear consensus is yet formed as to the item identification of the four factors originally proposed by Barrett-Lennard (1962).

Using a shortened version of the B-L RI that consisted of thirty two items a factor analysis was carried out using the data provided at sessions one and three for both clients and therapists from all vantage points. In all cases a Principal Components Analysis (PCA) was used with the Varimax method of rotation and the extraction of factors were specified as those having an Eigen Value greater than one. PCA’s were also carried out specifying four factors for extraction producing similar results to those shown below. For example, client’s and therapist’s responses indicated a single general factor accounted for most of the variance. When carrying out these analyses, in addition to specifying the four factor solution, a principal components analysis with an oblique rotation method was also carried out. The results did not provide a clear factor structure even when adding two sets of data together to increase the sample size. Further analyses in the future would be beneficial and could consider using confirmatory factor
analysis with LISREL and also residualising the single factor to consider the remaining items within the measure.

### 8.2.1 Session Three B-L RI Form 1: Client rating therapist conditions (OS form)

Clients completed the other to self (OS) RI that had been adapted to produce a set of items to describe the receiving person’s experience of the other person’s attitudes within the relationship. The OS measure has been used widely and is reported to be associated with positive outcome in psychotherapy studies (Gurman 1977). Sixty five clients completed the OS form in session three, a principal component factor analysis using the Varimax method of extraction produced seven factors with Eigenvalues equal to or greater than one that accounted for approximately seventy two percent of the total variance explained. The Keisar-Meyer-Olkin test of sampling adequacy gave a value of .78 giving a Bartlett’s test of sphericity a significance level $p < .0001$ suggesting the data was satisfactory for factor analysis.

Fifteen items loaded on the first factor that accounted for approximately forty three percent of the variance. However, after excluding variables that did not load heavily on this factor alone and using $\pm 0.48$ (Cramer 1986b) as the value that an item is considered to load highly on a single factor, thirteen items remained as loading heavily on the first factor (29, 12, 25, 2, 1, 20, 31, 18, 21, 10, 5, 9, 28). Five items are from the empathy subscale (29, 2, 18, 10 and 5), four from the regard subscale (1, 31, 21 and 9), three from the congruence subscale (12, 25, 20) and one from the unconditionality subscale (28). This factor was considered to be mixed and does not clearly identify with any of the subscales for the original RI.
Seven items (22, 26, 24, 32, 14, 11 and 30) loaded heavily on the second factor and accounted for approximately eight percent of the total variance explained. Two items (22 and 14) were from the empathy subscale, two items (11 and 30) from the unconditionality subscale, two (24 and 32) from the congruence subscale and one (26) from the regard subscale. This factor is also mixed and does not identify with any single subscale from the original RI. The third factor to emerge accounted for approximately five percent of the total variance explained and four items (6, 15, 23 and 7) loaded heavily. The first three items were from the unconditionality subscale and the fourth from the congruence subscale, however, this item also loaded heavily on the first factor. This factor is best identified as unconditionality and offers partial support for the unconditionality subscale in the RI.

Two items loaded on the fourth (3 and 16) one from the unconditionality (3) subscale and one from the congruence subscale (16) and this factor accounted for approximately four percent of the total variance explained. The fifth factor also accounted for approximately four percent of the variance and also had two items (19 and 17) loading heavily. The first item is from the unconditionality subscale and the second from the regard subscale. The remaining two factors each accounted for approximately four percent of the variance and had only a single item loading on each. The item (27) loading on the sixth factor was from the empathy subscale and the item (8) loading on the seventh factor was from the regard subscale. Factors four through to seven do not clearly identify as relating to any of the subscales from the RI and therefore are unable to lend support to the RI factor structure as comprising of four distinct subscales. In summary this analysis suggests a single factor solution for the B-L RI.
Table 8.1 Showing item loadings on each of the seven factors for Session 3 Client B-L RI Form 1 (OS)

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 1</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Empathy</td>
<td>.795</td>
<td>-.173</td>
<td>.058</td>
<td>-.232</td>
<td>-.140</td>
<td>-.150</td>
<td>-.302</td>
</tr>
<tr>
<td>12</td>
<td>Congruence</td>
<td>.770</td>
<td>-.238</td>
<td>.151</td>
<td>-.105</td>
<td>.057</td>
<td>-.193</td>
<td>.028</td>
</tr>
<tr>
<td>25</td>
<td>Congruence</td>
<td>.761</td>
<td>-.083</td>
<td>.337</td>
<td>-.107</td>
<td>-.106</td>
<td>-.139</td>
<td>.043</td>
</tr>
<tr>
<td>2</td>
<td>Empathy</td>
<td>.760</td>
<td>-.182</td>
<td>.105</td>
<td>-.111</td>
<td>-.381</td>
<td>-.165</td>
<td>.095</td>
</tr>
<tr>
<td>1</td>
<td>Level of regard</td>
<td>.759</td>
<td>-.174</td>
<td>.086</td>
<td>-.138</td>
<td>-.340</td>
<td>-.123</td>
<td>.018</td>
</tr>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>18</td>
<td>Empathy</td>
<td>.751</td>
<td>-.423</td>
<td>.163</td>
<td>-.053</td>
<td>.061</td>
<td>-.206</td>
<td>-.063</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>.759</td>
<td>-.174</td>
<td>.086</td>
<td>-.138</td>
<td>-.340</td>
<td>-.123</td>
<td>.018</td>
</tr>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>18</td>
<td>Empathy</td>
<td>.751</td>
<td>-.423</td>
<td>.163</td>
<td>-.053</td>
<td>.061</td>
<td>-.206</td>
<td>-.063</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>.759</td>
<td>-.174</td>
<td>.086</td>
<td>-.138</td>
<td>-.340</td>
<td>-.123</td>
<td>.018</td>
</tr>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>18</td>
<td>Empathy</td>
<td>.751</td>
<td>-.423</td>
<td>.163</td>
<td>-.053</td>
<td>.061</td>
<td>-.206</td>
<td>-.063</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>.759</td>
<td>-.174</td>
<td>.086</td>
<td>-.138</td>
<td>-.340</td>
<td>-.123</td>
<td>.018</td>
</tr>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>18</td>
<td>Empathy</td>
<td>.751</td>
<td>-.423</td>
<td>.163</td>
<td>-.053</td>
<td>.061</td>
<td>-.206</td>
<td>-.063</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>.759</td>
<td>-.174</td>
<td>.086</td>
<td>-.138</td>
<td>-.340</td>
<td>-.123</td>
<td>.018</td>
</tr>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>18</td>
<td>Empathy</td>
<td>.751</td>
<td>-.423</td>
<td>.163</td>
<td>-.053</td>
<td>.061</td>
<td>-.206</td>
<td>-.063</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>.751</td>
<td>-.187</td>
<td>.215</td>
<td>-.033</td>
<td>-.083</td>
<td>.051</td>
<td>-.052</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>.756</td>
<td>-.248</td>
<td>.110</td>
<td>-.205</td>
<td>.076</td>
<td>.201</td>
<td>.044</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>.759</td>
<td>-.174</td>
<td>.086</td>
<td>-.138</td>
<td>-.340</td>
<td>-.123</td>
<td>.018</td>
</tr>
</tbody>
</table>

# Factor 2

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 2</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Empathy</td>
<td>-.147</td>
<td>.792</td>
<td>-.044</td>
<td>.089</td>
<td>.077</td>
<td>.130</td>
<td>.239</td>
</tr>
<tr>
<td>26</td>
<td>Level of regard</td>
<td>-.332</td>
<td>.775</td>
<td>-.234</td>
<td>-.072</td>
<td>.237</td>
<td>-.010</td>
<td>-.082</td>
</tr>
<tr>
<td>4</td>
<td>Congruence</td>
<td>-.242</td>
<td>.700</td>
<td>-.045</td>
<td>.206</td>
<td>.104</td>
<td>-.214</td>
<td>.334</td>
</tr>
<tr>
<td>32</td>
<td>Congruence</td>
<td>-.279</td>
<td>.694</td>
<td>-.181</td>
<td>.331</td>
<td>.094</td>
<td>.127</td>
<td>-.080</td>
</tr>
<tr>
<td>14</td>
<td>Empathy</td>
<td>-.265</td>
<td>.672</td>
<td>-.102</td>
<td>.414</td>
<td>.033</td>
<td>.072</td>
<td>.110</td>
</tr>
<tr>
<td>11</td>
<td>Unconditionality</td>
<td>-.287</td>
<td>.567</td>
<td>-.070</td>
<td>.342</td>
<td>.185</td>
<td>.122</td>
<td>-.103</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>-.079</td>
<td>.474</td>
<td>-.387</td>
<td>.460</td>
<td>-.067</td>
<td>.325</td>
<td>-.028</td>
</tr>
</tbody>
</table>

# Factor 3

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 3</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Unconditionality</td>
<td>.066</td>
<td>-.057</td>
<td>.794</td>
<td>-.110</td>
<td>-.048</td>
<td>-.089</td>
<td>.107</td>
</tr>
<tr>
<td>15</td>
<td>Unconditionality</td>
<td>.278</td>
<td>-.044</td>
<td>.656</td>
<td>-.219</td>
<td>-.040</td>
<td>.245</td>
<td>-.222</td>
</tr>
<tr>
<td>23</td>
<td>Unconditionality</td>
<td>.354</td>
<td>-.268</td>
<td>.593</td>
<td>-.001</td>
<td>.037</td>
<td>-.245</td>
<td>-.050</td>
</tr>
<tr>
<td>7</td>
<td>Congruence</td>
<td>-.490</td>
<td>.293</td>
<td>-.517</td>
<td>-.045</td>
<td>-.026</td>
<td>.252</td>
<td>-.284</td>
</tr>
</tbody>
</table>

# Factor 4

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 4</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Unconditionality</td>
<td>-.127</td>
<td>.293</td>
<td>-.176</td>
<td>.768</td>
<td>.201</td>
<td>-.166</td>
<td>-.087</td>
</tr>
<tr>
<td>16</td>
<td>Congruence</td>
<td>-.256</td>
<td>.246</td>
<td>-.068</td>
<td>.713</td>
<td>.181</td>
<td>.325</td>
<td>.074</td>
</tr>
</tbody>
</table>

# Factor 5

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 5</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Unconditionality</td>
<td>-.043</td>
<td>.176</td>
<td>.027</td>
<td>.126</td>
<td>.799</td>
<td>-.007</td>
<td>.121</td>
</tr>
<tr>
<td>17</td>
<td>Level of regard</td>
<td>-.214</td>
<td>.338</td>
<td>-.156</td>
<td>.255</td>
<td>.524</td>
<td>.303</td>
<td>.165</td>
</tr>
</tbody>
</table>

# Factor 6

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 6</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Empathy</td>
<td>-.434</td>
<td>.143</td>
<td>-.139</td>
<td>.126</td>
<td>.098</td>
<td>.701</td>
<td>.027</td>
</tr>
</tbody>
</table>

# Factor 7

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 7</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>.020</td>
<td>.113</td>
<td>-.029</td>
<td>-.032</td>
<td>.124</td>
<td>.025</td>
<td>.798</td>
</tr>
</tbody>
</table>
8.2.2 Session Three, B-L RI Form 2: Client rating client conditions (MO form)
Using a principal components analysis the form completed by clients to assess their own attitudes towards the therapist in session three that reflects the myself to other (MO) perspective, a total of seven factors with Eigenvalues greater than one were extracted. The data were rotated using the Varimax method with Kaiser Normalisation and accounted for approximately seventy seven per cent of the total variance explained. The Keisar-Meyer-Olkin test of sampling adequacy gave a value of .80 giving a Bartlett's test of sphericity $p < .0001$ suggesting the data was satisfactory for factor analysis. The majority of items loaded onto the first five factors and the remaining three factors accounted exclusively for items from the unconditionality of regard subscale.

Using the ± 0.48 suggested above eight items loaded heavily on the first factor only (26, 17, 13, 22, 16, 14, 19 and 30) that accounted for approximately eighteen per cent of the variance. The first three items that loaded most heavily on this factor are from the level of regard subscale and all represent the expression of negative regard. The other five items that load on this factor are also negatively worded items. Two were from the empathy (22, 14) subscale and represent negatively worded expressions of this attitude towards the other; Two items are from (19, 30) are from the unconditionality subscale and the final item is from the congruence (16) subscale and represents negative expression of this attitudinal quality. The original level of regard subscale consists of both positively and negatively worded items which suggest this factor can not be identified and is not able to lend any substantial support for the level of regard subscale. However, this factor could possibly be identified as a subscale assessing a new construct that represents a general negative regard/attitude.
The second factor accounted for approximately sixteen per cent of the total variance explained. A total of six items (20, 25, 21, 29, and 7) loaded heavily on this factor. One item was from the empathy (29) subscale, three from the congruence (20, 25 and 7) subscale and one from the regard (21) subscale. This factor offers most support for the congruence subscale. However, as only three items from a possible eight congruence items load highly on this factor it is not possible to lend support for the congruence subscale as was defined in the original B-L RI.

The third factor has four items (15, 12, 10 and 3) that loaded heavily, two (15 and 3) from the unconditionality subscale, one (12) from the congruence and one (10) is from the empathy subscale. There is no support from this factor for any of the original four subscales of the B-L RI. Four items (2, 9, 31 and 4) loaded heavily on the fourth factor which accounted for nine per cent of the variance. The first two items are from the regard (9 and 31) subscale and one is from the congruence (4) subscale. The final item (2) is from the empathy subscale. This factor is also mixed and does not support the original B-L RI four factor model.

Three items (5, 27 and 24) loaded heavily on the fifth factor only which accounted for approximately nine per cent of the variance. Two items (5 and 27) were from the empathy subscale and the other from the congruence subscale (24). This factor is not representative of any of the original subscales. Finally, if the two remaining factors are collapsed they account for thirteen per cent of the variance with four items (11, 6, 23 and 28) loading heavily. Since all four items are from the unconditionality subscale these factors are best identified as unconditionality and can lend some support for this subscale of the original B-L RI.
Table 8.2 Showing item loadings on each of the seven factors for Session 3 Client B-L RI Form 2 (MO)

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 1</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Level of regard</td>
<td>.855</td>
<td>-.198</td>
<td>.055</td>
<td>-.092</td>
<td>-.131</td>
<td>-.001</td>
<td>-.014</td>
</tr>
<tr>
<td>17</td>
<td>Level of regard</td>
<td>.831</td>
<td>-.096</td>
<td>.026</td>
<td>.004</td>
<td>-.181</td>
<td>.058</td>
<td>-.099</td>
</tr>
<tr>
<td>13</td>
<td>Level of regard</td>
<td>.753</td>
<td>.031</td>
<td>.184</td>
<td>.186</td>
<td>-.166</td>
<td>-.192</td>
<td>.144</td>
</tr>
<tr>
<td>22</td>
<td>Empathy</td>
<td>.704</td>
<td>-.312</td>
<td>.220</td>
<td>.342</td>
<td>-.119</td>
<td>-.002</td>
<td>-.071</td>
</tr>
<tr>
<td>19</td>
<td>Unconditionality</td>
<td>.663</td>
<td>-.465</td>
<td>.029</td>
<td>.126</td>
<td>-.119</td>
<td>.015</td>
<td>.032</td>
</tr>
<tr>
<td>16</td>
<td>Congruence</td>
<td>.651</td>
<td>-.229</td>
<td>.372</td>
<td>.189</td>
<td>-.023</td>
<td>-.282</td>
<td>-.021</td>
</tr>
<tr>
<td>14</td>
<td>Empathy</td>
<td>.633</td>
<td>-.267</td>
<td>.391</td>
<td>.270</td>
<td>-.119</td>
<td>.015</td>
<td>.032</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>.589</td>
<td>-.158</td>
<td>.501</td>
<td>.216</td>
<td>.096</td>
<td>.150</td>
<td>-.110</td>
</tr>
<tr>
<td>#</td>
<td>Factor 2</td>
<td>F1</td>
<td>F2</td>
<td>F3</td>
<td>F4</td>
<td>F5</td>
<td>F6</td>
<td>F7</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>-.271</td>
<td>.856</td>
<td>-.245</td>
<td>.045</td>
<td>.068</td>
<td>.104</td>
<td>.121</td>
</tr>
<tr>
<td>25</td>
<td>Congruence</td>
<td>-.276</td>
<td>.824</td>
<td>-.202</td>
<td>.023</td>
<td>.101</td>
<td>.082</td>
<td>.154</td>
</tr>
<tr>
<td>21</td>
<td>Level of regard</td>
<td>-.113</td>
<td>.770</td>
<td>-.003</td>
<td>-.048</td>
<td>-.073</td>
<td>.283</td>
<td>.147</td>
</tr>
<tr>
<td>29</td>
<td>Empathy</td>
<td>-.137</td>
<td>.716</td>
<td>-.043</td>
<td>-.134</td>
<td>.388</td>
<td>-.062</td>
<td>.120</td>
</tr>
<tr>
<td>7</td>
<td>Congruence</td>
<td>.476</td>
<td>-.525</td>
<td>-.032</td>
<td>-.071</td>
<td>.196</td>
<td>.195</td>
<td>.154</td>
</tr>
<tr>
<td>#</td>
<td>Factor 3</td>
<td>F1</td>
<td>F2</td>
<td>F3</td>
<td>F4</td>
<td>F5</td>
<td>F6</td>
<td>F7</td>
</tr>
<tr>
<td>15</td>
<td>Unconditionality</td>
<td>.295</td>
<td>-.008</td>
<td>.881</td>
<td>.064</td>
<td>-.025</td>
<td>.039</td>
<td>-.063</td>
</tr>
<tr>
<td>12</td>
<td>Congruence</td>
<td>-.136</td>
<td>.356</td>
<td>-.614</td>
<td>-.116</td>
<td>.038</td>
<td>.298</td>
<td>.214</td>
</tr>
<tr>
<td>10</td>
<td>Empathy</td>
<td>-.156</td>
<td>.400</td>
<td>-.510</td>
<td>-.015</td>
<td>.488</td>
<td>.238</td>
<td>-.287</td>
</tr>
<tr>
<td>3</td>
<td>Unconditionality</td>
<td>.471</td>
<td>-.050</td>
<td>-.506</td>
<td>.026</td>
<td>.181</td>
<td>.038</td>
<td>.342</td>
</tr>
<tr>
<td>#</td>
<td>Factor 4</td>
<td>F1</td>
<td>F2</td>
<td>F3</td>
<td>F4</td>
<td>F5</td>
<td>F6</td>
<td>F7</td>
</tr>
<tr>
<td>2</td>
<td>Empathy</td>
<td>-.141</td>
<td>.092</td>
<td>-.007</td>
<td>.822</td>
<td>-.237</td>
<td>-.079</td>
<td>-.231</td>
</tr>
<tr>
<td>9</td>
<td>Level of regard</td>
<td>-.250</td>
<td>.324</td>
<td>.180</td>
<td>.646</td>
<td>-.133</td>
<td>.280</td>
<td>.288</td>
</tr>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>-.250</td>
<td>.324</td>
<td>.180</td>
<td>.513</td>
<td>-.023</td>
<td>.271</td>
<td>.253</td>
</tr>
<tr>
<td>4</td>
<td>Congruence</td>
<td>-.174</td>
<td>.337</td>
<td>.345</td>
<td>.505</td>
<td>.011</td>
<td>-.444</td>
<td>-.191</td>
</tr>
<tr>
<td>#</td>
<td>Factor 5</td>
<td>F1</td>
<td>F2</td>
<td>F3</td>
<td>F4</td>
<td>F5</td>
<td>F6</td>
<td>F7</td>
</tr>
<tr>
<td>5</td>
<td>Empathy</td>
<td>.174</td>
<td>-.122</td>
<td>.053</td>
<td>-.027</td>
<td>.837</td>
<td>.070</td>
<td>.025</td>
</tr>
<tr>
<td>27</td>
<td>Empathy</td>
<td>.167</td>
<td>.112</td>
<td>.217</td>
<td>-.410</td>
<td>.717</td>
<td>-.029</td>
<td>-.225</td>
</tr>
<tr>
<td>24</td>
<td>Congruence</td>
<td>.402</td>
<td>-.002</td>
<td>.263</td>
<td>-.140</td>
<td>.560</td>
<td>-.365</td>
<td>-.180</td>
</tr>
<tr>
<td>#</td>
<td>Factor 6</td>
<td>F1</td>
<td>F2</td>
<td>F3</td>
<td>F4</td>
<td>F5</td>
<td>F6</td>
<td>F7</td>
</tr>
<tr>
<td>11</td>
<td>Unconditionality</td>
<td>-.051</td>
<td>.161</td>
<td>-.064</td>
<td>.039</td>
<td>.071</td>
<td>.825</td>
<td>.027</td>
</tr>
<tr>
<td>6</td>
<td>Unconditionality</td>
<td>.400</td>
<td>-.156</td>
<td>.218</td>
<td>.312</td>
<td>.048</td>
<td>-.510</td>
<td>-.018</td>
</tr>
<tr>
<td>#</td>
<td>Factor 7</td>
<td>F1</td>
<td>F2</td>
<td>F3</td>
<td>F4</td>
<td>F5</td>
<td>F6</td>
<td>F7</td>
</tr>
<tr>
<td>23</td>
<td>Unconditionality</td>
<td>-.034</td>
<td>.181</td>
<td>-.074</td>
<td>-.132</td>
<td>.028</td>
<td>-.089</td>
<td>.869</td>
</tr>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>.002</td>
<td>.194</td>
<td>-.086</td>
<td>.087</td>
<td>.073</td>
<td>.467</td>
<td>.660</td>
</tr>
</tbody>
</table>
8.2.3 Session Three B-L RI Form3: therapist rating therapist conditions (MO form)

The ‘myself to other’ (MO) form was also completed by eleven therapists based on their therapeutic relationships with a total of seventy clients. The procedure followed that for clients and forms for the purpose of this analysis were completed at the end of the third session. The data was subjected to a factor analysis using the principal components method and the Varimax method of rotation. The initial analysis specified an Eigenvalue greater than or equal to one and produced a seven factor solution that accounted for approximately seventy six percent of the total variance explained. The Keisar-Meyer-Olkin test of sampling adequacy gave a value of .75 giving a Bartlett’s test of sphericity $p < .0001$ suggesting the data was satisfactory for factor analysis.

Using a value of $± 0.48$ as the level at which an item is considered to be highly loading on any factor and when only items loading highly on one factor are considered then eight items loaded highly on the first factor (27, 5, 18, 29, 20, 4, 24 and 25). The first four highest loading items are from the empathy subscale of the original version of the B-L RI and the next four are from the congruence subscale. As was noted in the method section the empathy items in MO form generally tend to have a greater emphasis in measuring a particular aspect of the empathic process. This possibly does not allow the person who is scoring to rate the extent to which they believe they communicate their understanding. This could provide an explanation of why several items from the congruence subscale that relate to the communication of feeling or attitude towards the other are correlated with the empathy items. The congruence items that load highly on this factor appear to relate to empathic resonance, in being open to oneself and having an inner stillness, both requirements of the empathic process. This factor only lends tentative support for the original empathy subscale but may also be understood as representing a new definition of an expressive or communicative empathy subscale within the MO form.
Six items (17, 8, 26, 13, 7 and 21) loaded highly on the second largest factor which accounted for approximately ten percent of the total variance explained. Of these, five were from the regard (17, 8, 26, 13 and 21) subscale and one from the congruence (7) subscale. All but one of the items were worded negatively and this factor is best described as representing the level of negative regard experienced.

The third factor accounted for approximately six percent of the variance and six items loaded heavily on this factor alone with three from the unconditionality (6, 15 and 23) subscale, two from the empathy (14 and 10) subscale and one from the congruence (12) subscale. This factor would appear to be mixed and not wholly representative of the original four factors of the RI. However, a closer analysis could suggest that as the one item (14) from the empathy subscale and both items from the congruence subscale represent consistency in feeling or attitude towards the other, the criteria for unconditionality have also been met in these items. However, this analysis may be stretching the interpretation of the meaning of these items and therefore for purpose of this analysis this factor is best identified as mixed and not lending sufficient support for the unconditionality subscale. That being said, it may provide the basis for further exploration as a new subscale for unconditionality/ consistency.

The fourth factor accounted for approximately five percent of the total variance explained. Three items loaded heavily on this factor alone. All three were from the regard (31, 1 and 9) subscale. Each of the three items was worded positively and this factor most represents the regard scale and is identified in the present study as positive regard.
Table 8.3: Showing item loadings on each of the seven factors for Session 3
Therapist B-L RI Form 3 (MO)

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 1</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Empathy</td>
<td>-0.821</td>
<td>0.152</td>
<td>-0.134</td>
<td>-0.089</td>
<td>0.143</td>
<td>-0.002</td>
<td>0.034</td>
</tr>
<tr>
<td>5</td>
<td>Empathy</td>
<td>-0.784</td>
<td>0.004</td>
<td>-0.198</td>
<td>-0.017</td>
<td>0.127</td>
<td>0.265</td>
<td>-0.166</td>
</tr>
<tr>
<td>18</td>
<td>Empathy</td>
<td>0.746</td>
<td>-0.191</td>
<td>0.286</td>
<td>0.154</td>
<td>0.086</td>
<td>-0.101</td>
<td>0.241</td>
</tr>
<tr>
<td>29</td>
<td>Empathy</td>
<td>0.703</td>
<td>-0.323</td>
<td>0.308</td>
<td>0.172</td>
<td>-0.074</td>
<td>-0.129</td>
<td>0.145</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>0.664</td>
<td>-0.192</td>
<td>0.286</td>
<td>0.268</td>
<td>-0.253</td>
<td>0.061</td>
<td>0.027</td>
</tr>
<tr>
<td>4</td>
<td>Congruence</td>
<td>0.609</td>
<td>-0.170</td>
<td>0.196</td>
<td>0.383</td>
<td>-0.245</td>
<td>-0.283</td>
<td>-0.042</td>
</tr>
<tr>
<td>24</td>
<td>Congruence</td>
<td>-0.569</td>
<td>0.133</td>
<td>-0.391</td>
<td>-0.077</td>
<td>0.097</td>
<td>0.436</td>
<td>-0.088</td>
</tr>
<tr>
<td>25</td>
<td>Congruence</td>
<td>0.532</td>
<td>-0.386</td>
<td>0.109</td>
<td>0.412</td>
<td>-0.252</td>
<td>-0.042</td>
<td>0.233</td>
</tr>
<tr>
<td>17</td>
<td>Level of regard</td>
<td>-0.157</td>
<td>0.898</td>
<td>-0.157</td>
<td>-0.122</td>
<td>0.087</td>
<td>0.079</td>
<td>-0.037</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>-0.157</td>
<td>0.898</td>
<td>-0.157</td>
<td>-0.122</td>
<td>0.087</td>
<td>0.079</td>
<td>-0.037</td>
</tr>
<tr>
<td>26</td>
<td>Level of regard</td>
<td>-0.273</td>
<td>0.883</td>
<td>-0.131</td>
<td>-0.034</td>
<td>0.128</td>
<td>0.050</td>
<td>-0.007</td>
</tr>
<tr>
<td>13</td>
<td>Level of regard</td>
<td>-0.155</td>
<td>0.869</td>
<td>-0.034</td>
<td>-0.129</td>
<td>0.185</td>
<td>0.140</td>
<td>-0.138</td>
</tr>
<tr>
<td>7</td>
<td>Congruence</td>
<td>-0.008</td>
<td>0.761</td>
<td>-0.148</td>
<td>-0.364</td>
<td>0.091</td>
<td>0.151</td>
<td>-0.036</td>
</tr>
<tr>
<td>21</td>
<td>Level of regard</td>
<td>-0.321</td>
<td>0.611</td>
<td>-0.122</td>
<td>-0.214</td>
<td>0.031</td>
<td>0.456</td>
<td>0.049</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 2</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Level of regard</td>
<td>-0.157</td>
<td>0.898</td>
<td>-0.157</td>
<td>-0.122</td>
<td>0.087</td>
<td>0.079</td>
<td>-0.037</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>-0.157</td>
<td>0.898</td>
<td>-0.157</td>
<td>-0.122</td>
<td>0.087</td>
<td>0.079</td>
<td>-0.037</td>
</tr>
<tr>
<td>26</td>
<td>Level of regard</td>
<td>-0.273</td>
<td>0.883</td>
<td>-0.131</td>
<td>-0.034</td>
<td>0.128</td>
<td>0.050</td>
<td>-0.007</td>
</tr>
<tr>
<td>13</td>
<td>Level of regard</td>
<td>-0.155</td>
<td>0.869</td>
<td>-0.034</td>
<td>-0.129</td>
<td>0.185</td>
<td>0.140</td>
<td>-0.138</td>
</tr>
<tr>
<td>7</td>
<td>Congruence</td>
<td>-0.008</td>
<td>0.761</td>
<td>-0.148</td>
<td>-0.364</td>
<td>0.091</td>
<td>0.151</td>
<td>-0.036</td>
</tr>
<tr>
<td>21</td>
<td>Level of regard</td>
<td>-0.321</td>
<td>0.611</td>
<td>-0.122</td>
<td>-0.214</td>
<td>0.031</td>
<td>0.456</td>
<td>0.049</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 3</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Empathy</td>
<td>-0.008</td>
<td>0.178</td>
<td>-0.787</td>
<td>-0.129</td>
<td>0.284</td>
<td>-0.165</td>
<td>0.025</td>
</tr>
<tr>
<td>15</td>
<td>Unconditionality</td>
<td>0.156</td>
<td>-0.097</td>
<td>0.776</td>
<td>0.241</td>
<td>0.088</td>
<td>-0.034</td>
<td>-0.021</td>
</tr>
<tr>
<td>23</td>
<td>Unconditionality</td>
<td>0.254</td>
<td>-0.168</td>
<td>0.619</td>
<td>0.110</td>
<td>-0.083</td>
<td>-0.330</td>
<td>-0.102</td>
</tr>
<tr>
<td>10</td>
<td>Empathy</td>
<td>0.417</td>
<td>-0.215</td>
<td>0.578</td>
<td>0.297</td>
<td>0.121</td>
<td>-0.327</td>
<td>0.150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 4</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>0.230</td>
<td>-0.129</td>
<td>-0.051</td>
<td>0.770</td>
<td>-0.167</td>
<td>-0.106</td>
<td>-0.009</td>
</tr>
<tr>
<td>1</td>
<td>Level of regard</td>
<td>0.211</td>
<td>-0.246</td>
<td>0.105</td>
<td>0.729</td>
<td>-0.226</td>
<td>-0.319</td>
<td>0.032</td>
</tr>
<tr>
<td>9</td>
<td>Level of regard</td>
<td>0.381</td>
<td>-0.276</td>
<td>0.366</td>
<td>0.563</td>
<td>-0.021</td>
<td>0.071</td>
<td>0.322</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 5</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Congruence</td>
<td>-0.227</td>
<td>0.126</td>
<td>-0.075</td>
<td>-0.133</td>
<td>0.811</td>
<td>0.120</td>
<td>-0.189</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>-0.152</td>
<td>0.463</td>
<td>-0.168</td>
<td>-0.126</td>
<td>0.701</td>
<td>0.047</td>
<td>0.115</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 6</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Unconditionality</td>
<td>-0.138</td>
<td>0.282</td>
<td>-0.123</td>
<td>-0.203</td>
<td>0.109</td>
<td>0.769</td>
<td>-0.177</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 7</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
<th>F7</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>0.187</td>
<td>-0.044</td>
<td>0.574</td>
<td>-0.045</td>
<td>0.036</td>
<td>-0.218</td>
<td>0.671</td>
</tr>
<tr>
<td>11</td>
<td>Unconditionality</td>
<td>-0.432</td>
<td>0.223</td>
<td>0.191</td>
<td>-0.217</td>
<td>0.369</td>
<td>0.045</td>
<td>-0.515</td>
</tr>
</tbody>
</table>
Finally, five items loaded heavily on the last three factors, two on the fifth factor (16 and 30), one on the sixth (19) and two on the seventh (28 and 11). The variance accounted for by each of these factors was four percent, three percent and three percent respectively. Four of the five items are from the unconditionality (30, 19, 11 and 28) subscale and one from the congruence (16) subscale. Two items did not load heavily on any factor, one from the empathy (22) subscale and one from the unconditionality (3) subscale.

The findings from this analysis do not lend support for the four factor structure of the original RI. There is some evidence for reconceptualising the congruence items as representative of the communication component of therapeutic empathy and consistency in unconditional positive regard. On this basis, no clear factor structure was found.

**8.2.4 Session Three B-L RI Form 4: therapist rating client conditions (OS form)**

Finally, using the Principal Components method and the Varimax method of rotation a factor analysis was carried out on the data for the RI. The analysis produced a six factor solution with Eigenvalues greater than or equal to one. The six factors accounted for approximately seventy three percent of the total variance explained with most items loading on the first four factors. The Keisar-Meyer-Olkin test of sampling adequacy gave a value of .77 giving a Bartlett’s test of sphericity $p < .0001$ suggesting the data was satisfactory for factor analysis.

Where the criterion for high loading factors is any item that loads on a factor ± 0.48 seven items (25, 20, 29, 12, 21, 32 and 18) loaded highly on the first factor that accounted for approximately forty seven per cent of the variance. Four of the seven items were from the congruence subscale (25, 20, 12, 32), two from the empathy
subscale (29 and 18) and one from the regard subscale (21). This factor is mixed and fails to lend support to the congruence subscale. The second largest factor had seven items (23, 15, 3, 14, 6, 28 and 9) loading highly on it and accounted for approximately eight per cent of the variance. Five of these items (23, 15, 3, 6 and 28) were from the unconditionality subscale, one from the empathy subscale (14) and one from the regard subscale (9). Based on this the second factor can be identified as representing the unconditionality subscale.

The third largest factor accounted for approximately seven percent of the total variance explained and had six items (16, 26, 17, 11, 8 and 7) loading heavily. Three items were from the regard subscale (26, 17, 8), two from the congruence subscale (16 and 7) and one from the unconditionality subscale (11). All of the items loading on this factor were worded negatively. As with the factor analysis for the MO form completed by clients after the third session, this factor lends partial support for the identification of a new subscale representing level of negative regard. However, this factor fails to lend support for the original regard subscale.

The fourth factor accounted for approximately four per cent of the total variance explained and had six items (5, 24, 22, 13, 30 and 10) loading heavily on it. Three of these items are from the empathy subscale (5, 22 and 10), with one from the congruence (24), regard (13) and unconditionality (30) subscales. This factor is mixed and therefore cannot lend support for the original empathy subscale. Three items loaded highly on each of the fifth (1, 4 and 2) and sixth (31, 19 and 27) factors which accounted for approximately four per cent and three percent respectively of the total variance explained.
Table 8.4 Showing item loadings on each of the seven factors for Session 3
Therapist B-L RI Form 4 (OS)

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 1</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Congruence</td>
<td>0.827</td>
<td>0.215</td>
<td>-0.190</td>
<td>-0.134</td>
<td>0.225</td>
<td>0.036</td>
</tr>
<tr>
<td>20</td>
<td>Congruence</td>
<td>0.812</td>
<td>0.192</td>
<td>-0.296</td>
<td>-0.037</td>
<td>0.166</td>
<td>0.026</td>
</tr>
<tr>
<td>29</td>
<td>Empathy</td>
<td>0.751</td>
<td>0.207</td>
<td>-0.155</td>
<td>-0.298</td>
<td>0.100</td>
<td>0.277</td>
</tr>
<tr>
<td>12</td>
<td>Congruence</td>
<td>0.735</td>
<td>0.266</td>
<td>-0.122</td>
<td>-0.181</td>
<td>0.311</td>
<td>0.201</td>
</tr>
<tr>
<td>21</td>
<td>Level of regard</td>
<td>0.721</td>
<td>0.179</td>
<td>-0.273</td>
<td>-0.147</td>
<td>0.174</td>
<td>0.097</td>
</tr>
<tr>
<td>32</td>
<td>Congruence</td>
<td>-0.713</td>
<td>-0.311</td>
<td>0.186</td>
<td>0.220</td>
<td>-0.070</td>
<td>-0.018</td>
</tr>
<tr>
<td>18</td>
<td>Empathy</td>
<td>0.603</td>
<td>0.172</td>
<td>-0.177</td>
<td>-0.386</td>
<td>0.002</td>
<td>0.385</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 2</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Unconditionality</td>
<td>0.138</td>
<td>0.838</td>
<td>-0.156</td>
<td>-0.116</td>
<td>0.140</td>
<td>0.235</td>
</tr>
<tr>
<td>15</td>
<td>Unconditionality</td>
<td>0.266</td>
<td>0.768</td>
<td>-0.009</td>
<td>-0.121</td>
<td>0.189</td>
<td>0.256</td>
</tr>
<tr>
<td>3</td>
<td>Unconditionality</td>
<td>-0.223</td>
<td>-0.715</td>
<td>0.057</td>
<td>0.500</td>
<td>0.036</td>
<td>0.088</td>
</tr>
<tr>
<td>14</td>
<td>Empathy</td>
<td>-0.351</td>
<td>-0.690</td>
<td>0.144</td>
<td>0.144</td>
<td>0.223</td>
<td>0.062</td>
</tr>
<tr>
<td>6</td>
<td>Unconditionality</td>
<td>0.123</td>
<td>0.674</td>
<td>-0.153</td>
<td>-0.075</td>
<td>0.366</td>
<td>0.134</td>
</tr>
<tr>
<td>28</td>
<td>Unconditionality</td>
<td>0.458</td>
<td>0.607</td>
<td>-0.127</td>
<td>-0.163</td>
<td>0.026</td>
<td>0.357</td>
</tr>
<tr>
<td>9</td>
<td>Level of regard</td>
<td>0.309</td>
<td>0.512</td>
<td>-0.227</td>
<td>-0.318</td>
<td>0.318</td>
<td>0.275</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 3</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Congruence</td>
<td>-0.269</td>
<td>-0.083</td>
<td>0.788</td>
<td>0.156</td>
<td>-0.249</td>
<td>0.002</td>
</tr>
<tr>
<td>26</td>
<td>Level of regard</td>
<td>-0.291</td>
<td>-0.078</td>
<td>0.782</td>
<td>0.190</td>
<td>-0.063</td>
<td>-0.125</td>
</tr>
<tr>
<td>17</td>
<td>Level of regard</td>
<td>-0.266</td>
<td>-0.213</td>
<td>0.694</td>
<td>0.019</td>
<td>-0.227</td>
<td>-0.111</td>
</tr>
<tr>
<td>11</td>
<td>Unconditionality</td>
<td>-0.110</td>
<td>-0.063</td>
<td>0.616</td>
<td>0.342</td>
<td>-0.014</td>
<td>-0.245</td>
</tr>
<tr>
<td>8</td>
<td>Level of regard</td>
<td>-0.048</td>
<td>-0.128</td>
<td>0.536</td>
<td>0.531</td>
<td>-0.245</td>
<td>0.050</td>
</tr>
<tr>
<td>7</td>
<td>Congruence</td>
<td>-0.318</td>
<td>-0.038</td>
<td>0.507</td>
<td>0.282</td>
<td>-0.492</td>
<td>-0.101</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 4</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Empathy</td>
<td>-0.339</td>
<td>-0.178</td>
<td>0.127</td>
<td>0.771</td>
<td>-0.274</td>
<td>-0.183</td>
</tr>
<tr>
<td>24</td>
<td>Congruence</td>
<td>-0.377</td>
<td>-0.393</td>
<td>0.187</td>
<td>0.719</td>
<td>0.102</td>
<td>0.069</td>
</tr>
<tr>
<td>22</td>
<td>Empathy</td>
<td>-0.184</td>
<td>-0.079</td>
<td>0.468</td>
<td>0.665</td>
<td>0.082</td>
<td>-0.168</td>
</tr>
<tr>
<td>13</td>
<td>Level of regard</td>
<td>-0.031</td>
<td>-0.140</td>
<td>0.216</td>
<td>0.591</td>
<td>-0.319</td>
<td>-0.193</td>
</tr>
<tr>
<td>30</td>
<td>Unconditionality</td>
<td>-0.156</td>
<td>-0.170</td>
<td>0.555</td>
<td>0.558</td>
<td>-0.127</td>
<td>-0.217</td>
</tr>
<tr>
<td>10</td>
<td>Empathy</td>
<td>0.462</td>
<td>0.303</td>
<td>0.004</td>
<td>-0.553</td>
<td>0.288</td>
<td>0.258</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 5</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Level of regard</td>
<td>0.285</td>
<td>0.128</td>
<td>-0.211</td>
<td>-0.204</td>
<td>0.772</td>
<td>0.116</td>
</tr>
<tr>
<td>4</td>
<td>Congruence</td>
<td>0.542</td>
<td>0.135</td>
<td>-0.264</td>
<td>-0.167</td>
<td>0.561</td>
<td>0.007</td>
</tr>
<tr>
<td>2</td>
<td>Empathy</td>
<td>0.376</td>
<td>0.082</td>
<td>-0.347</td>
<td>0.027</td>
<td>0.463</td>
<td>0.075</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Factor 6</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>F6</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Level of regard</td>
<td>0.419</td>
<td>0.244</td>
<td>-0.056</td>
<td>-0.323</td>
<td>0.087</td>
<td>0.694</td>
</tr>
<tr>
<td>19</td>
<td>Unconditionality</td>
<td>-0.041</td>
<td>-0.296</td>
<td>0.485</td>
<td>0.050</td>
<td>-0.202</td>
<td>-0.675</td>
</tr>
<tr>
<td>27</td>
<td>Empathy</td>
<td>-0.183</td>
<td>-0.270</td>
<td>0.389</td>
<td>0.421</td>
<td>-0.006</td>
<td>-0.541</td>
</tr>
</tbody>
</table>

210
8.2.5 Summary of factor analyses
The interpretation of the findings of this series of factor analyses is subject to three main limitations. First, despite this being an attempt to confirm the four factor model of the B-L RI, the method used was an exploratory approach to factor analysis. There was not enough support in any of the analyses presented above for the original four factor structure of the B-L RI. This finding directs the possibilities in regards to moving forward within the results section using the separate empathy, level of regard, unconditionality and congruence subscales defined by Barrett-Lennard (1962). On the basis of the findings from the factor analyses all subsequent analysis in the results sections below use a composite measure for the relationship inventory.

Second, there was a relatively small sample size in relation to the number of items in the questionnaires which may have acted as a limiting variable in the sensitivity of the tests in order to identify clear factors representing the distinct subscales (Bryman and Cramer, 2005). Third, for the purpose of reducing the burden upon the clients the RI was reduced to half of its original number of items. It is possible that a number of the thirty two items included in this study may not have been items which the participants were able to discriminate as being from the different subscales; this may also have resulted in the lack of support being offered. Given that previous findings have found support for the distinct subscales of the RI it could be suggested that points two and three above can argue the case either way. That is, for either a composite RI measure or for the distinct subscales. However, it is also necessary that each separate study sample is able to distinguish what precisely is being measured and therefore, based on all these reasons the remaining statistical analyses were carried out using the composite score for the general quality of the therapeutic relationship.
Chapter 9

Results

Assessing the quality of the therapeutic relationship
9.1 Changes in relationship conditions
The following section of results looks at the quality of the therapeutic relationship, changes in the rating of the therapeutic relationship and the association of the therapeutic relationship with outcome. Rogers's (1959) theory suggests that during the course of effective therapy the levels of the therapeutic conditions will increase. Specifically the theoretical proposition suggests that as the client receives the unconditional positive regard and empathic understanding of the therapist, the client themselves come to have greater levels of positive self regard and self understanding which in turn lead to greater congruence in the relationship. These relationship conditions are more freely available to the client to offer in a reciprocal manner to the therapist and thus the client is more able to accurately perceive the conditions available from the therapist. This suggests the cycle continues over time with greater levels of the conditions being available and subsequently perceived.

9.1.1 B-L RI Descriptive data
This study used a composite measure of a shortened B-L RI to assess the quality of the therapeutic conditions also referred to as the necessary and sufficient conditions for therapeutic change (Rogers 1957). The composite measure was calculated as the mean score for all thirty two items. At the same time as completing the CORE-OM, sixty two clients also completed the B-L RI questionnaires. The quality of the therapeutic relationship was assessed using ratings from four perspectives; client perception of therapist conditions (B-L RI 1 – C-OS), client own rating of the therapeutic conditions towards the therapist (B-L RI 2 – C-MO), therapist rating of their own therapeutic conditions provided to the client (B-L RI 3 – T-MO) and finally, therapist perception of client provided conditions (B-L RI 4 – T-OS). Table 9.1.1 shows the alpha reliabilities,
mean and standard deviation for the B-L RI scores for the first and third sessions as rated by both clients and therapists. The effect size (es) for changes between sessions one and three in the perceived quality of the therapeutic conditions was calculated using Cohen’s d using the pooled standard deviation for client rating of therapist conditions (.33) and client rating of client conditions (.32), therapist rating of therapist conditions (.18) and therapist rating of client conditions (.45).

Table 9.1.1 Means, standard deviations and alpha reliabilities for session one and session three B-L RI

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Cronbach’s α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-OS</td>
<td>62</td>
<td>4.5</td>
<td>.57</td>
<td>.92</td>
</tr>
<tr>
<td>C-MO</td>
<td>62</td>
<td>4.4</td>
<td>.58</td>
<td>.90</td>
</tr>
<tr>
<td>T-MO</td>
<td>62</td>
<td>5.0</td>
<td>.54</td>
<td>.94</td>
</tr>
<tr>
<td>T-OS</td>
<td>62</td>
<td>4.3</td>
<td>.68</td>
<td>.96</td>
</tr>
<tr>
<td>Session 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-OS</td>
<td>62</td>
<td>4.7</td>
<td>.65</td>
<td>.94</td>
</tr>
<tr>
<td>C-MO</td>
<td>62</td>
<td>4.6</td>
<td>.66</td>
<td>.94</td>
</tr>
<tr>
<td>T-MO</td>
<td>62</td>
<td>5.1</td>
<td>.59</td>
<td>.95</td>
</tr>
<tr>
<td>T-OS</td>
<td>62</td>
<td>4.6</td>
<td>.64</td>
<td>.96</td>
</tr>
</tbody>
</table>

(C - Client, T - Therapist, OS - Other to Self, MO – Myself to Other)

9.1.2 Perceived changes in the quality of the therapeutic relationship across session one, three and five
As noted in the section above looking at scores for the CORE-OM those who continued and returned data at session five were not significantly more or less distressed than those who either ended therapy or failed to return data after session three. First it is important to assess the differences in scores provided for the RI across the first three sessions. This was necessary to determine whether those who continued in therapy to session five had perceived the quality of the therapeutic relationship and experienced levels of the therapeutic conditions to a greater or lesser degree.
A repeated measures ANOVA was used to test for differences in RI scores of the perceived quality of the therapeutic relationship across time. Using the RI the multivariate $F$ - tests showed a significant difference across the three data collection points for scores provided from all vantage points of assessment. That is, significant differences were found over time between the client rating of therapist provided conditions ($F = 11.243\ (df =2),\ p < 0.000,\ n = 33$), client rating of client conditions ($F = 8.703\ (df =2),\ p < 0.001,\ n = 32$), therapist rating of therapist conditions ($F = 4.79\ (df =2),\ p < 0.015,\ n = 36$) and therapist rating of client conditions ($F = 15.51\ (df =2),\ p < 0.000,\ n = 36$).

The repeated measures ANOVA provided an $F$ score that indicated a significant difference in RI scores for the three separate time points entered. However, this test alone does not explain where this difference lies (Bryman and Cramer 2008). To determine where the difference lies between the three related time points, related $t$-tests were used to pin point the significant differences in perception of the quality of the relationship. This was done by comparing the scores between the first and third sessions and then again for the third and fifth sessions.

The perceived quality of the therapeutic relationship increased significantly over the first three sessions. For example, client rating of therapist therapeutic conditions was significantly greater at session three than in session one ($t\ (62) = - 4.505,\ p < 0.001$). Therapist rating of therapist conditions ($t\ (62) = - 1.781,\ p = 0.08$) was not significantly different at session three compared with session one, however this did approach significance. Clients rating of their own therapeutic conditions towards their therapist was significantly higher in session three than session one ($t\ (62) = - 5.642,\ p < 0.001$) and therapist rating of the client feelings towards the therapist ($t\ (62) = - 5.853,\ p < 0.001$)
was also significantly greater in session three than in session one. Interestingly, no significant improvement in the perceived quality of the therapeutic relationship was found between session three and session five neither for client or therapist rating of the therapist held conditions nor for client or therapist ratings of the client feeling towards the therapist.

9.1.2.1

Differences in RI scores for clients that completed three and five sessions

One way analysis of variance was used to test for differences in early levels of the therapeutic conditions for those that completed three sessions and those that completed five sessions. The analysis showed no significant differences in the level of client and

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RI Score Completed 3 sessions</td>
<td>RI Score Completed 5 sessions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C - OS</td>
<td>4.44</td>
<td>.51</td>
<td>4.54</td>
<td>.61</td>
<td>60</td>
<td>.457</td>
<td>ns</td>
</tr>
<tr>
<td>C - MO</td>
<td>4.37</td>
<td>.49</td>
<td>4.37</td>
<td>.68</td>
<td>60</td>
<td>.001</td>
<td>ns</td>
</tr>
<tr>
<td>T - MO</td>
<td>5.06</td>
<td>.53</td>
<td>5.0</td>
<td>.55</td>
<td>60</td>
<td>.169</td>
<td>ns</td>
</tr>
<tr>
<td>T - OS</td>
<td>4.37</td>
<td>.72</td>
<td>4.29</td>
<td>.66</td>
<td>60</td>
<td>.201</td>
<td>ns</td>
</tr>
<tr>
<td>Session 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C - OS</td>
<td>4.62</td>
<td>.61</td>
<td>4.76</td>
<td>.69</td>
<td>60</td>
<td>.663</td>
<td>ns</td>
</tr>
<tr>
<td>C - MO</td>
<td>4.57</td>
<td>.61</td>
<td>4.66</td>
<td>.71</td>
<td>60</td>
<td>.325</td>
<td>ns</td>
</tr>
<tr>
<td>T - MO</td>
<td>5.09</td>
<td>.65</td>
<td>5.11</td>
<td>.52</td>
<td>60</td>
<td>.033</td>
<td>ns</td>
</tr>
<tr>
<td>T - OS</td>
<td>4.64</td>
<td>.77</td>
<td>4.61</td>
<td>.50</td>
<td>60</td>
<td>.025</td>
<td>ns</td>
</tr>
</tbody>
</table>
therapist perceived therapist conditions or client and therapist perception of client provided conditions at session one between those that completed three session or went on to complete five. Table 9.1.2.1 above shows the means, standard deviations, degrees of freedom, F ratio and significance level for the ANOVA.

9.1.2.2 Summary
The finding supports the view that the quality of the therapeutic relationship increases over time, thus lending some support to Rogers (1959) hypothesis. It also suggests that the majority of gains in the perceived quality of the therapeutic relationship were achieved over the first three sessions of therapy. This was the case whether the clients ended therapy or provided data only in sessions one and three or whether the client continued in therapy and provided data through to session five. This is consistent with the findings of previous research which suggests an association between significant gains and the therapeutic relationship that are made early in therapy.

9.1.3 Exploring the differences and inter-correlations for session one, three and five shortened B-L RI score for clients and therapists
Gurman (1977) suggests that research has shown a preference for clients’ ratings of the therapeutic relationship to predict outcome more reliably than therapist or observer ratings. In addition to this, there seems to be little concordance between the various perspectives for assessing the quality of the therapeutic relationship. The following analyses looks at the extent to which the client and therapist ratings of the therapeutic relationship were associated with one another.
9.1.3.1 Client and therapist rating of therapist provided therapeutic conditions
There was little consensus over the degree to which the client and therapist rated the level of therapeutic conditions provided by the therapist. Therapists tended to see themselves as providing higher levels of the therapeutic conditions than was reportedly perceived by clients. Therapist rated provision of their own levels of the therapeutic conditions towards the client were significantly higher than client rating of therapist provided conditions in session one ($t = -5.50, p < 0.001$ two-tailed), session three ($t = -3.81, p < 0.001$ two-tailed) and session five ($t = -2.16, p < 0.05$ two-tailed). A mismatch seems to be apparent in the extent to which clients and therapists experience the level of the therapist provided therapeutic conditions within the therapeutic relationship. The difference between client and therapist rating of therapist provided conditions was less in session five than in session three and even more so in comparison with the difference observed in session one. This shifting towards greater equivalence perhaps lends further support to the hypothesis stated above that there is a general move towards higher levels of reciprocity in the therapeutic relationship over time.

9.1.3.2 Client and therapist rating of client provided conditions
Interestingly, in contrast to the finding above clients and therapists provided similar means scores for the level of client provided conditions and there was virtually no difference between the way clients and therapists rated the level of client provided therapeutic conditions in session one ($t = 0.04, p > 0.05$ two-tailed), session three ($t = -0.04, p > 0.05$ two-tailed) and session five ($t = -0.04, p > 0.05$ two-tailed). This finding suggests a greater degree of consistency between clients and therapists in the perception of the mean level of client conditions being provided within the therapeutic relationship.
These two findings raise important issues in determining the potential accuracy in perceiving the level of therapeutic conditions available. Knowing whether the differences are attributable to inaccuracies in perception may be an important issue worthy of exploration. This finding may provide some explanation of the inconsistencies in the findings of previous research studies which have suggested an equivocal association between the therapeutic relationship and outcome. For example, the differences between client and therapist ratings of therapist provided conditions may be due to the client not accurately perceiving the presence of therapist held conditions. Whereas, the similar mean scores in the client and therapist rating of client provided conditions may suggest therapists are better at identifying the attitudinal qualities held by the client. This could be explained further by suggesting that in their perception of the therapeutic conditions held by the therapist, clients rely more on the behavioural components displayed by therapists.

This point is returned to later in the section below on interaction analyses but first it is necessary to explore further the differences in the mean RI scores identified above with correlation analyses. This will give a more powerful indication of the specific perceptions of the relationship between client and therapist dyads.

9.1.3.3 Inter-correlations for client and therapist rating of the therapeutic relationship
Comparing the mean scores is a helpful way to test the overall difference between perceived levels of the therapeutic conditions rated by therapists and clients. However, a more robust measure of the association between the ratings of these two perceptual
vantage points is to explore the correlations between therapist and client ratings of the therapeutic relationship from each vantage point and for each session.

The inter-correlation matrix presented in Table 9.1.3.3 below shows, as might be expected in light of the findings above, no significant correlations were observed between client and therapist rating of therapist provided conditions in session one ($r = 0.057, p = .662$), session three ($r = 0.082, p = .525$) or session five ($r = 0.048, p = .790$).

### Table 9.1.3.3 showing inter-correlations for client and therapist rating of therapeutic conditions using B-L RI for MO and OS ($p < 0.01^{**}$ two tailed)

<table>
<thead>
<tr>
<th>Measure/Session</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. C - OS</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. C - MO</td>
<td>.82**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. T - MO</td>
<td>.06</td>
<td>.16</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. T - OS</td>
<td>-.02</td>
<td>.11</td>
<td>.70**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. C - OS</td>
<td>.84**</td>
<td>.79**</td>
<td>.17</td>
<td>.05</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. C - MO</td>
<td>.80**</td>
<td>.85**</td>
<td>.15</td>
<td>.05</td>
<td>.92**</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. T - MO</td>
<td>-.08</td>
<td>.05</td>
<td>.82**</td>
<td>.65**</td>
<td>.08</td>
<td>.10</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Session 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. T - OS</td>
<td>-.10</td>
<td>.00</td>
<td>.69**</td>
<td>.82**</td>
<td>.03</td>
<td>.06</td>
<td>.84**</td>
<td>1.00</td>
</tr>
</tbody>
</table>

In addition to this, and in spite of the degree of consistency between clients and therapists rating of the mean level of therapeutic conditions provided by the client, no significant correlations were found between client and therapist ratings of the clients
conditions towards the therapist for session one \( (r = 0.106, p = .413) \), session three \( (r = 0.058, p = .657) \) or session five \( (r = 0.075, p = .685) \). This in conjunction with the above finding for rating of therapist provided conditions suggest that clients and therapists are not able to predict each others scores using ratings of the quality of the therapeutic relationship with regard to both the perception of how they feel towards the other and how they perceive the other feels towards them.

9.1.3.4 Reciprocity
Earlier researchers found the way people feel toward one another to be reciprocally related to the way they perceive the other person feels towards them (Cramer and Weston 2004). In the current study it was important to test whether the level of perceived relationship conditions being provided by the other was reciprocally associated with the therapeutic conditions that clients and therapists themselves experienced towards the other.

There was a high association between the levels of perceived conditions from the other with those experienced towards the other. Client rating of the therapeutic conditions received from the therapist was significantly correlated with the level of therapeutic conditions clients experienced towards the therapist in session one \( (r = 0.816, p < .001) \), session three \( (r = 0.923, p < .001) \) and session five \( (r = 0.925, p < .001) \). There was also a high level of significance between therapist rating of the therapeutic conditions they provided and those they received from the client in session one \( (r = 0.704, p < .001) \), session three \( (r = 0.835, p < .001) \) and session five \( (r = 0.776, p < .001) \).
There was a higher level of reciprocity for client rating of the therapeutic conditions than therapist ratings. The size of the correlations exceeds those required for satisfactory test-retest reliability correlation (0.7) and suggests these two perspectives are possibly measuring the same variable. However, it could alternatively be argued that the reciprocity between the various vantage points for rating the therapeutic relationship supports the hypothesis that client perception of the quality of the therapeutic relationship is reciprocally related to their own increasing capacity for interpersonal relating (Rogers, 1959). This issue is returned to later in more detail in the sections covering the therapeutic relationship and outcome and when exploring mutuality.

9.1.3.5 Summary
The results so far have shown that clients and therapists rate therapist conditions significantly greater than client conditions and that these scores significantly increased over the first three sessions of therapy. Similarly, the results found that client and therapist ratings of the client provided conditions increased over the early stages of therapy. Therapists and clients showed consistency in the mean level of therapeutic conditions however, there were no significant correlations between the therapist and client rating of their own or other provided conditions. As both the client and therapist view of the relationship conditions they provided was so highly significantly correlated with their view of what the other provided to them suggests a new variable labelled here as reciprocity indicating that only a single mutual relational variable exists within both client and therapist.
9.1.4 The association between the therapeutic relationship and outcome

As noted earlier in the literature review section a number of positions exist in relation to the association between the therapeutic relationship and outcome. The sceptical view of the positive association between measures of the therapeutic relationship and measures of outcome is that such associations are the result of clinical improvement (Zuroff and Blatt 2006). This argument posits that as client distress level improves so does their perception of the positive nature of the therapeutic relationship. This is often presented as a significant limitation to the research which supports a significant role for the therapeutic relationship in producing positive outcomes. However, this is because most studies of the therapeutic relationship have explored the association between the relationship conditions and outcome by examining data collected at a single point in time.

An alternative view is that the positive association between the therapeutic relationship and improvement in the outcome of psychotherapy may be due to spurious variables (Cramer 1996). This view suggests that the positive changes in the relationship and outcome are caused by some other unknown variable affecting both the perceived quality of the therapeutic relationship and the outcome of therapy. The present study collected longitudinal data of the perceived quality of the therapeutic relationship and outcome during the first three sessions of therapy. Presented below in Table 9.3.4 are the Pearson correlation coefficients for the various correlations produced by the analysis for the RI and CORE-OM for sessions one and three. Partial correlations are also provided where session one level of distress is controlled and are also presented Table 9.1.4.
Table 9.1.4 Correlations for B-L RI MO and OS and CORE-OM

<table>
<thead>
<tr>
<th>Session 1</th>
<th>B-L RI</th>
<th>Session 1 CORE-OM</th>
<th>Session 3 CORE-OM</th>
<th>Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE-OM</td>
<td>1.00</td>
<td>.58**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C - OS</td>
<td>-.13</td>
<td>-.24*</td>
<td>-.20</td>
<td></td>
</tr>
<tr>
<td>C - MO</td>
<td>-.10</td>
<td>-.21†</td>
<td>-.18</td>
<td></td>
</tr>
<tr>
<td>T - MO</td>
<td>.21†</td>
<td>-.00</td>
<td>-.15</td>
<td></td>
</tr>
<tr>
<td>T - OS</td>
<td>.19</td>
<td>-.01</td>
<td>-.15</td>
<td></td>
</tr>
<tr>
<td>Session 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C - OS</td>
<td>-.06</td>
<td>-.25*</td>
<td>-.27*</td>
<td></td>
</tr>
<tr>
<td>C - MO</td>
<td>-.06</td>
<td>-.25*</td>
<td>-.26*</td>
<td></td>
</tr>
<tr>
<td>T - MO</td>
<td>.14</td>
<td>-.01</td>
<td>-.11</td>
<td></td>
</tr>
<tr>
<td>T - OS</td>
<td>.11</td>
<td>-.11</td>
<td>-.24*</td>
<td></td>
</tr>
</tbody>
</table>

(n = 62 p < 0.01** one tailed, p < 0.05* one tailed, p = 0.05† one tailed, partial correlation = session 3 CORE-OM controlling for Session 1 CORE-OM one tailed)

9.1.4.1 Session one RI ratings and session one CORE-OM
The correlations calculated using Pearson’s $r$ is shown in Table 9.3.4 above. Session one therapist rating of their own therapeutic conditions provided to the client (T-MO) and client rated session one CORE-OM were significantly and positively correlated ($r$ (n=62) = .21, $p = 0.05$) at the one tailed level. This suggests that therapists perceived themselves as experiencing higher levels of the therapeutic conditions towards those clients who were less distressed. No further significant correlations were found between the RI and CORE-OM at session one for any other vantage point.
9.1.4.2 Session one RI ratings and session three CORE-OM

In line with the prediction that early therapeutic conditions reliably predict later outcome, client ratings of therapist provided therapeutic conditions (C- OS) at session one was significantly correlated with outcome in session three \( (r_{n=62} = - .24, \ p < 0.05) \) at the one tailed level and approached significance at the two tailed level \( (r = - .24, \ p = 0.06) \). This correlation remained close to significance when controlling for session one outcome producing a partial correlation of \( r = - .20, \ p = 0.06 \), at the one tailed level. Additionally, this association remained stable when controlling for other variables such as the client sex \( (r = - .25) \), age \( (r = - .29) \), medication \( (r = - .29) \), ethnicity \( (r = - .29) \), therapeutic approach \( (r = - .26) \), therapist experience \( (r = - .28) \), and therapist age \( (r = - .29) \) all of which produced a significant \( (p < 0.05) \) partial correlation at the one tailed level.

Client’s rating of their own experiencing of the therapeutic conditions towards the therapist (C- MO) in session one, was associated with CORE-OM at session three \( (r = - .21, \ p = 0.05) \) at the one tailed level. This result also maintained the level of significance at the one tailed level when controlling for client sex, age, ethnicity and medication.

In contrast to this, therapist ratings of their own conditions towards the client (T – MO) at session one did not correlate with CORE-OM in session three with a near zero order association being found \( (r = - .004, \ p = 0.49) \). In addition to this, therapists again failed to predict outcome when using the measure of therapist ratings of client provided therapeutic conditions (T – OS) in session one and client rated CORE-OM in session three, again yielding a near zero order correlation \( (r = - .013, \ p = 0.46) \).
9.1.4.3 Session three synchronous correlations
When looking at the association between the ratings for the therapeutic conditions in session three and client reported outcome in session three, two further significant correlations were found. The client rating of therapist provided therapeutic conditions (C – OS) in session three and session three outcome were significantly correlated at the one tailed level \( r(n=62) = -0.25, p = 0.02 \) and two tailed level \( r(n=62) = -0.25, p < 0.05 \). Additionally, clients rating of their own experiencing of therapeutic conditions towards the therapist (C – MO) was also significantly correlated with CORE-OM at the one tailed level \( r(n=62) = -0.25, p = 0.03 \) and at the two tailed level \( r(n=62) = -0.25, p = 0.05 \). However, neither session three therapist rating of their own conditions towards the client (T – MO) \( r = -0.01, p = 0.47 \), nor therapist rating of client feelings towards the therapist (T – OS) \( r = -0.107, p = 0.20 \) were significantly correlated with session three CORE-OM.

9.1.4.4 Reciprocity and outcome
Given that the level of perceived therapeutic conditions provided or received are highly associated with one another when they are assessed from a single vantage point it was decided a worthwhile process collapsing these two variables into one variable to create a new variable that can be called reciprocity. As suggested above the reciprocity variable is theoretically coherent with Rogers (1959) proposals and arguably offers the most realistic measure of the whole relationship as it is perceived from either the therapist or the client.

It was hypothesised that high reciprocity will be significantly negatively correlated with low levels of distress measured using CORE-OM. As the client has proved to be the
most reliable predictor of outcome at both sessions one and session three this variable was created from the client’s perspective and related to outcome.

Reciprocity at session one was significantly correlated with outcome at session three ($r = -0.211, p = 0.05$ one tailed). The correlation between reciprocity at session three and outcome at session three had greater significance ($r = -0.244, p < 0.05$ one tailed). In exploring the association over time using a partial correlation controlling for outcome at session one, reciprocity at session three and outcome at session three was even more strongly associated ($r = -0.263, p < 0.05$ two tailed).

To measure the effect of reciprocity on outcome over time, session one reciprocity was associated with session three outcome and produced a correlation in the order of $r = -0.21$ and approached significance ($p = 0.05$) at the one tailed level. When controlling for the effect of distress at session one a correlation in the order of $r = -0.18$ ($p < 0.08$) was obtained that remained close to significant at the one tailed level. These results suggest that high reciprocity is associated with positive outcome both when being observed synchronously and over time.

9.2 Does the relationship predict outcome or outcome predict the relationship

It was noted earlier that the suggestion has been made that the perceived positive quality of the therapeutic relationship by the client is the result of positive changes the client makes in therapy. One way to test this is to use the ratings of the therapeutic relationship at session one and session three and explore the correlations with outcome at session one and session three. Cross lagged correlations can be used as a test of
spuriousness. Whilst a direct causal relation between the variables cannot be assumed in the model predicted below it is reasonable to accept that spurious effect of improvement leading to perceived better relationship can be ruled out if the correlation between time one relationship conditions and time two CORE-OM is stronger that time one CORE-OM and time two relationship conditions. This analysis was carried out using a form of structural equation modeling and the LISREL software package.

9.2.1 Cross lagged correlations for client perceived therapeutic conditions and outcome at session one and session three
The cross lagged correlations shown in Figure 9.2.1 below suggest that session one client perceived therapist conditions is more strongly correlated with session three outcome than session one outcome is correlated with session three therapeutic conditions.

The coefficients shown are from the structural equation model and support the view that early levels of the therapeutic conditions lead to later lower levels of client reported distress rather than early distress leading to higher levels of perceived relationship conditions.
Figure 9.2.1 Cross lagged correlation panel analysis for client assessment of therapist provided therapeutic conditions in session one and session three with session one and session three CORE outcome. (P < 0.05*, P < 0.01**, P < 0.001***)

The LISREL analysis produced a range of goodness of fit indices. The goodness of fit was assessed using a Normal Theory Weighted Least Squares Chi Square and Root Means Square Error of Approximation (RMSEA). A good fit for the data would requires the Chi Square to be non significant and the RMSEA to be close to 0.06. The model was not a good fit for the data however, as a Chi Square of $X^2 = 20.54$ ($p < 0.001$) and RMSEA of 0.40 were found.

9.3 Assessing direct and indirect effects of the therapeutic relationship on outcome.
The following sections are an analysis of the direct and indirect effects of the therapeutic relationship conditions on outcome. To do this, a form of structural equation modeling was used to develop and test a series of models. This approach is also referred to as
path analysis. It is possible to test for the relationships between the variables that measure the therapeutic relationship conditions from multiple perspectives using this method and consider the contribution they make towards outcome. Causality cannot be inferred, however, the path diagrams are designed to show the causal logic underlying the proposed models. The models tested below aim to explore the effects of the therapeutic relationship as it is perceived from both sides. This involves looking at the way that the client and therapist perceive the therapist to be providing the therapeutic conditions and the way that the client feels towards the therapist.

9.3.1 Path analysis for session one client and therapist rating of therapist conditions on session three client perceptions of therapist conditions and outcome.

Rogers’ (1957) theory suggests that as the client feels genuinely empathically understood and unconditionally accepted the client reciprocates these conditions and then moves towards greater and more accurate perception of the therapeutic conditions provided by the therapist. The purpose of the LISREL analysis in the first predicted model was to explore effects of session one client perception of therapist provided conditions and session one therapist perception of providing the conditions on outcome in session three and, as Rogers’ hypothesis suggests, on session three levels of the client rating of the therapist provided conditions. The principle underlying the models is that early levels of therapeutic conditions, both perceived and received, will lead to positive change in outcome and also to higher later perceived levels of the therapeutic conditions. Table 9.3.2 below shows the direct effect of session one client perception of therapist provided conditions (Cl – OS₁) on session three client perception of therapist provided conditions (Cl – OS₃) and on outcome in session three (CORE₃) and also the indirect effect on outcome through session three client perception of therapist
Table 9.3.2 Path coefficients for the direct, indirect and total effects for the model in path diagram 9.3.2

<table>
<thead>
<tr>
<th>Path/variable</th>
<th>Direct effect</th>
<th>Indirect effect</th>
<th>Total effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cli – OS₁</td>
<td>-0.08</td>
<td>-0.16</td>
<td>-0.24</td>
</tr>
<tr>
<td>Cli – OS₃</td>
<td>-0.19</td>
<td>-0.19</td>
<td>-0.19</td>
</tr>
<tr>
<td>Th - MO₁</td>
<td>0.03</td>
<td>0.02</td>
<td>0.05</td>
</tr>
</tbody>
</table>

provided conditions (CI – OS₃). The path analysis also explores the indirect effect of the therapist perception of own conditions provided to the client (T – MO₁) on outcome through session three client perception of therapist provided conditions (CI – OS₃) and directly on outcome in session three (CORE₃). The path model is shown below in Figure 9.3.1 with the coefficients shown on the diagram. The model is specified from left right indicating the causal logic underlying the model with the temporal sequencing of the model also moving from left to right.

Bryman and Cramer (2005) have suggested it is helpful to try and understand the overall impact that each variable has on outcome by calculating the effect coefficient (Padhazur, 1982). The table above shows the path coefficients for the direct, indirect and total effects. It appears from this the indirect effect of Cli – OS₁ on outcome is inconsistent with its direct effect suggesting that understanding the intervening variable Cli – OS₃ is essential to an understanding of the effect of early levels of the therapeutic relationship and later reported levels of outcome.
The direct and indirect effect of Th - MO₁ are consistent with one another and are weakly related to outcome. In comparing the total effects of all variables in the model it is implied that Cli – OS₁ has the largest overall effect on outcome and supports the view from the cross lagged correlation above that early therapeutic conditions predicts later outcome.

The LISREL analysis produced a range of goodness of fit indices. The goodness of fit was assessed using a Normal Theory Weighted Least Squares Chi Square and Root Means Square Error of Approximation (RMSEA). As stated above a good fit for the data would requires the Chi Square to be non significant and the RMSEA to be close to 0.06. The model was not a good fit for the data however, as a Chi Square of $X^2 = 11.06$ ($P < 0.05$*, $P < 0.01$**, $P < 0.001$***).
0.001) and RMSEA of 0.41 were found. The modification index in LISREL suggested that a path from session three CORE-OM to session three client perception of therapist provided conditions be included.

9.3.2 Path analysis for session one client rating of therapist and client conditions on session three client perceptions of therapist conditions and outcome.
The model above tested the effects of session one client and therapist ratings of therapist provided conditions on later levels of client rating of therapist conditions and on outcome. The following model again tests the effects of session one client perception of therapist provided conditions on session three level of this variable and session three outcome; however, this time the client’s own attitude towards the therapist is also being explored within the model. The purpose of the LISREL analysis in the second predicted model was to test the rationale that there is a reciprocal relationship between how the client perceives the therapist and how the client they themselves feel towards the therapist. Rogers’ (1959) theory stated that a psychological chain reaction is activated when the client experiences the therapeutic conditions from the therapist they will subsequently experience higher levels of these same conditions towards others. The path diagram in Figure 9.32 below shows the various paths and coefficients produced.
The results in this analysis suggest that the direct effect of the level of therapeutic conditions the client perceives from the therapist in session one on outcome is larger than the indirect effect.

Table 9.3.2 Showing the path coefficients for the direct, indirect and total effects for the model in path diagram 9.5.2

<table>
<thead>
<tr>
<th>Path/variable</th>
<th>Direct effect</th>
<th>Indirect effect</th>
<th>Total effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cli – OS₁</td>
<td>- 0.24</td>
<td>- 0.21</td>
<td>- 0.45</td>
</tr>
<tr>
<td>Cli - MO₁</td>
<td>- 0.20</td>
<td>- 0.20</td>
<td>- 0.40</td>
</tr>
<tr>
<td>Cli – OS₃</td>
<td>- 0.11</td>
<td>- 0.11</td>
<td>- 0.11</td>
</tr>
</tbody>
</table>
The coefficients for the direct, indirect and total effect are shown in table 9.3.2 above. Once again the path model was specified to indicate the causal logic within the model not necessarily an actual casual relationship. The left to right sequence also indicates the temporality within the model suggesting time one variables predict those at time two. Taking a comparison of the total effects of each of the three variables in the model it appears that client perception of early levels of the therapeutic conditions has the greatest effect on outcome in session three. The goodness of fit was tested using the same method as above. The model provided a reasonable fit for the data satisfying the criteria for a non significant Normal Weighted Least Squares Chi Square ($X^2 = 0.011; p = 0.92$), however the RMSEA was not satisfactory (0.0) meaning the goodness of fit was only partially fulfilled.

### 9.4 Summary

The analyses suggest that during the initial stages of therapy therapists provided higher levels of the therapeutic conditions to those clients experiencing lower levels of distress. Therapist ratings of the therapeutic relationship conditions proved to be a poor predictor of outcome using the CORE-OM. However, clients on the other hand were shown to be able to perceive therapist conditions at session one at a level that predicted subsequent outcome in session three. This finding was significant and lends support to the view that the early therapeutic relationship is predictive of later therapeutic outcome even when controlling for the early levels of distress. Clients were also able to provide session three scores that produced reliable synchronous correlation between their own level of the therapeutic conditions experienced towards the therapist and their perception of the therapist’s conditions towards them with outcome.
It is important to understand that the temporal sequencing of the path models is demonstrative of the causal logic underlying the models and not necessarily the actual causal relations. For example, caution must be taken when interpreting these findings as no causal relations can be assumed. Each of the models above was specified to show causal logic over time, however, the data collected for time two relationship variables and time two CORE-OM are taken from session three in both instances. The CORE-OM has a response time frame indicating how the client has felt ‘over the last seven’ days meaning that some of the response may contain a bias for change that preceded the response given for the relationship variable. Even accounting for this, the path analyses have shown that the variable session one rating of client perception of therapist provided conditions has the greatest effect on outcome in session three. This was the case when tested in two separate structural equation models looking at the direct and indirect effects of the client and therapist therapeutic conditions perceived and provided. This finding leads on to the next section of the results that looks specifically at the notion of mutuality within the therapeutic relationship.
Chapter 10

Results

Mutuality and outcome
10.1 Introduction to moderation analyses
The main question being addressed within the thesis is whether Rogers’s claim that the
therapeutic relationship can be experienced as mutual and that when it is experienced
the same on both sides then therapeutic change occurs. To address this research
question it was necessary to develop a metric for assessing mutuality. The best test for
the effect of mutuality of the relationship conditions on outcome was identified as a test
of moderation (Baron and Kenny, 1986).

In determining the precise nature of mutuality within the therapeutic relationship two
analyses were required. The first test for the moderating variable for a test of mutuality
can be thought of as follows: the association between outcome and clients’ perception of
therapist provided conditions (C - OS) will be more positive when therapist’s views of
their own conditions (T – MO) are high rather than low. This test will determine whether
mutuality, defined as the extent to which client and therapist both experience the
therapist as providing high or low levels of the therapeutic conditions, is related to
outcome.

The second test will determine whether mutuality, defined as the extent to which client
and therapist both perceive the other as providing high or low levels of the therapeutic
conditions, is related to outcome. This can be tested by the association between
outcome and clients’ perception of therapist provided conditions (C - OS) will be more
positive when therapist’s views of the client provided conditions (T – OS) are high rather
than low.

The best way to test for moderation with variables which use score based data is
hierarchical multiple regression (Cramer In Press). Aiken and West (1991) have
suggested that the criterion and two predictor variables are standardised before completing the analysis. This approach will also tell us if there is a significant interaction effect from which we can assume that moderation has occurred.

10.1.1 Moderator effects for Therapist MO on the association between Client OS and Session 3 CORE-OM

Table 10.1.1 Regression summary for moderator effect of T - MO on the association between C - OS and session 3 CORE-OM

<table>
<thead>
<tr>
<th></th>
<th>β Regression weight</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept (Constant)</td>
<td>1.45</td>
<td>17.83</td>
<td>.000</td>
</tr>
<tr>
<td>Client OS (standardised)</td>
<td>-.30</td>
<td>-2.44</td>
<td>.02</td>
</tr>
<tr>
<td>Therapist MO (standardised)</td>
<td>-.15</td>
<td>-.87</td>
<td>.39</td>
</tr>
<tr>
<td>Interaction</td>
<td>-.33</td>
<td>-2.46</td>
<td>.02</td>
</tr>
</tbody>
</table>

Following these recommendations a significant amount of the variance in CORE-OM at session three was accounted for by the interaction between C - OS and T - MO scores on the RI at session three after the individual variables were controlled, $R^2$ change = .088, $p < .02$. The interaction was interpreted by plotting two separate unstandardised regression lines between standardised session three C - OS, standardised T - MO and the standardised level of session three CORE-OM. The lines are shown with the regression coefficients for each line shown in the Figure 10.1.1 below.
The final step of the moderation analysis involved converting the moderator variable (Session 3 T - MO) into two separate groups, one representing those scores above the mean as representative of the high scores and the other representing the low scores that fell below the mean. The level of C - OS for each group was then correlated with the dependent variable to produce a coefficient of $r = .308$ for the high group and $r = -.110$ for the low group. The interaction plot for the regression coefficients confirms there was a significant moderating effect for the high and low scoring groups of therapist MO. The results suggest that client OS scores are more strongly associated with CORE-OM at session three when therapist MO scores are high rather than low. It would seem that when therapists and clients perceive there to be mutually high levels of therapist provided therapeutic conditions then scores on CORE-OM are lowest suggesting that the outcome of psychotherapy is best. This analysis supports Rogers' view of there being an association between mutuality and therapeutic change.
10.1.2 Moderator effect for Therapist OS on the association between Client OS and Session 3 CORE-OM

The analysis above tested the mutuality of the therapeutic conditions via moderation. The analysis used the client and therapist ratings of the therapist provided therapeutic conditions. The following analysis again uses hierarchical multiple regression as the test for mutuality via moderation. The following is an analysis of mutuality of therapist and client ‘other to self’ ratings of the therapeutic conditions on outcome. This will test for the moderating effect of therapist view of client provided conditions (Therapist OS) on the association between client OS and CORE-OM. The scores used represent data collected at session three. Following these recommendations a significant amount of the variance in CORE-OM at session three was accounted for by the interaction between client OS and therapist OS scores on the RI at session three after the individual variables were controlled, $R^2$ change = .073, $p < .03$. The regression weightings and significance levels are shown in the table below.

Table 10.1.2 Regression summary for moderator effect of T-OS on association between C-OS and session 3 CORE_OM

<table>
<thead>
<tr>
<th></th>
<th>$\beta$ Regression weight</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>1.44</td>
<td>17.68</td>
<td>.000</td>
</tr>
<tr>
<td>Client OS</td>
<td>-.271</td>
<td>-2.225</td>
<td>.03</td>
</tr>
<tr>
<td>Therapist OS</td>
<td>-.194</td>
<td>-1.511</td>
<td>.136</td>
</tr>
<tr>
<td>Interaction</td>
<td>-.287</td>
<td>-2.219</td>
<td>.03</td>
</tr>
</tbody>
</table>

The interaction was interpreted by plotting two separate unstandardised regression lines between standardised session three client OS, standardised therapist MO and the
standardised level of session three CORE-OM. The lines are shown with the regression coefficients for each of the lines shown in the Figure 10.4.1 below.

![Figure 10.4.1 Interaction plot for moderating effect of Th - OS on the association between Cli – OS and CORE-OM in session three.]

**Figure 10.1.2 Interaction plot for moderating effect of Th - OS on the association between Cli – OS and CORE-OM in session three.**

**10.1.3 Summary**

The findings showed a significant moderator effect of therapist OS on the association between client OS and CORE-OM at session three. This suggests that when both clients and therapists indicate high perceived levels of the therapeutic conditions as being provided then the CORE-OM scores appear to be lower. Putting this another way, client ratings of therapist conditions appear to be a stronger predictor of outcome when therapists also experience the client as providing higher rather than lower levels of the therapeutic conditions. The two moderation analyses produced very similar findings suggesting that mutuality is associated with outcome regardless of the position one takes on the definition of mutuality set out at the beginning of this chapter.
Chapter 11
Discussion
Effectiveness of psychotherapy
11.1 Effectiveness of psychotherapy
The major purpose of this study was to explore the association between mutuality and psychotherapy outcome. It was proposed that the mutuality of the therapeutic conditions of empathy, unconditional positive regard and congruence would be measured and where found to be present the association with outcome would be positively observed. Through the literature review it was proposed that mutuality can be considered in two ways, firstly, as the mutual experiencing by the client and therapist of the therapist as being genuinely empathic and unconditionally accepting of the client. Or, second that client and therapist mutually perceive the other as being genuinely empathic and unconditionally accepting of one another. These perspectives were considered by looking at the levels of the therapeutic conditions in the third session of psychotherapy and the synchronous association with outcome. The results from this study showed that mutuality did occur in both of the terms defined above and that when mutuality was observed this was related to positive outcome.

The general discussion provided below looks at these results and explores the possible explanations for the findings that were observed. First, the discussion looks at the overall effectiveness of the psychotherapy provided and contextualises the findings within this study. In this study psychotherapy was found to be successful and is in support of the significant amount of previous psychotherapy research which has found psychotherapy to be effective in alleviating psychological distress (Elliott, Greenberg & Leitaer, 2004; Lambert & Ogles, 2004; Luborsky et al, 2002; Shapiro & Shapiro, 1982; Smith & Glass, 1977; Smith, Glass & Miller, 1980). Following this, there is a discussion of the factor analysis and some considerations of the findings are provided. Next the discussion focuses on the issue of mutuality and considers the ways that mutuality may be
conceived within psychotherapy and its relation to outcome. Finally, this is followed by a summary of the limitations of the present study, some recommendations for further study and a summary of conclusions.

11.1.1 Reliable and clinically significant improvement
The results showed that a quarter of clients who received psychotherapy in the present study achieved reliable and clinically significant improvement within the first three sessions. The mean score for the session one CORE was 1.95 was above the clinical cut off score of 0.99 suggested by Connell, Barkham, Stiles, Twigg, Singleton, Evans and Miles (2007). Additionally, as the majority of data in the present study was collected within a university counseling and psychotherapy setting, this finding supports the suggestion that the severity of people seeking psychological therapy in university student support centres experience similar levels of distress to those who seek help in primary care locations (Connell, Barkham & Mellor-Clark, 2007).

The likelihood of achieving significant improvement during this early stage of therapy could be considered low. For example, Lambert and Ogles (2004) have suggested that the average number of sessions reported to be required before clinical change occurs within twenty five percent of the sample is seven sessions. Twenty four percent of clients in this study achieved this after just three sessions suggesting that the therapy in this study expedited change. One possible alternative explanation for the findings in the current study is that the majority of clients who made up this naturalistic study were able to access therapeutic support very soon after presenting to the service to request help. Of the sixty two clients included in the analysis of clinical and reliable improvement and completed and returned full sets of data after session three, over half had accessed
therapy in a university setting. This means that from the time they requested an appointment and the time at which they received their first appointment, less than two weeks had passed. Receiving clients into the study with fluctuating levels of distress and who may actually be in a state of high distress due to a transient situation may inadvertently have skewed the data. For example, the client’s situation outside of the therapeutic environment may have changed significantly over the three week period in which they accessed therapy and provided data. In line with the finding of Assay and Lambert (1999) client extra-therapeutic factors may also have been a change agent responsible for some of the findings here.

However, extratherapeutic factors are unlikely to account for all of the change observed and given that the total group mean for the sample did not cross the threshold into a sub clinical mean score it is reasonable to assume that on average clients whilst improving did remain distressed even at the end of the study and that their distress was significant and not that of a short term crisis. Future studies that have greater resources could consider continuing the data collection process beyond this stage or even build in a follow up stage to assess the changes that were made during the study.

The question of change and how much therapy is enough is an important one to consider for any psychotherapy process and outcome study especially where change appears to have occurred at an early stage in the therapeutic process. As Barkham et al (1996) suggested change occurs at a negatively accelerating rate and Hass, Hill, Lambert and Morrell (2002) found that early change is related to end of therapy status as well as follow up there is a good reason to believe the change observed here is reliable. In addition to this the findings of Hardy, Stiles, Cahill, Ispan, MacAskill and Barkham (2005) suggest that the rate of client improvement is also sharpest at the beginning of
therapy it is likely that the results observed in the present study can be considered a reliable reflection of lasting change.

Reducing the criteria for improvement from clinically reliable change to reliable change can also be helpful. Lambert, Hansen and Finch (2001) found that data from naturalistic therapy settings in a sample of over six thousand clients showed that fifty percent of clients improved after just seven sessions. The present study exceeded this finding with forty seven percent of clients achieving reliable change after just three sessions of therapy. Using the reliable change index independently of the clinical cut off scores means it is difficult to compare clinical change across studies. However, given that it is possible that each individual sample used in each study may have its own clinical cut off point in relation to a matched normal population comparisons across studies need to be made tentatively.

11.1.2 Degree of client change – effect size
Reliable and clinically significant change is a helpful way for determining change at the individual client level. However, it is also helpful to consider the size of the effect of psychotherapy at the group or study level. Testing and reporting the size of the treatment effect in a study is useful as a comparison to previous findings and also for the results to be tested against further studies in the future. Using Cohen’s $d$ the average effect size in this study was calculated to be 0.85 and falls into the bracket for a large effect. A large effect size has been estimated to be in the region of 0.8 or above (Wampold, 2001). Stiles et al (2006) in their study of primary care therapy found a much larger pre-post effect size ($d = 1.36$). However, it should be noted that the average length of therapy for clients in the Stiles et al (2006) study was longer and ranged
between a mean of 6.11 sessions for person-centred therapy and 8.53 for psychodynamic therapy with CBT clients receiving a mean of 6.52 sessions.

As noted above the present study observed a significant amount of change in the first three sessions of psychotherapy and thus produced a large effect. As stated above when considering the rates of reliable and clinically significant improvement this may have been attributable to the particular client population used as a sample. However, Lambert and Ogles (2004) have noted that clients in routine practice receive a much lower number of sessions compared with those who take part in clinical trials. For example, clients in routine practice settings may only receive as few as on average 5-7 sessions. Indeed the service average for the De Montfort University service was four sessions. The findings in this study reflect the notion that clients achieve a good standard of improvement early in therapy and will often terminate at this point. This has been suggested elsewhere as the ‘good enough’ level of improvement. Here Barkham et al (2006) have suggested that clients using psychotherapy services in primary care contexts end therapy when they have achieved a good enough level of improvement. It could be argued that this explains the significant number of clients in the present study who did not complete therapy to session five and ended after session three whilst achieving a satisfactory level of improvement.

11.1.3 Deterioration
Whilst it appears that in general therapy was effective not all clients in the present study improved as a result of attending therapy. Two clients (3.2 per cent) showed reliable deterioration in levels of distress over the first three sessions of therapy. This finding is significantly lower than that reported in general with the number of clients who show
deterioration over the whole course of therapy having been suggested as approximately ten percent (Lambert and Ogles, 2004). This figure however, includes studies that were part of clinical trials and those where data was collected from studies of routine practice. Improvement in clinical trials is typically better than in naturalistic studies as it is often the most motivated and straightforward client presentations that are included in clinical trials. It is important to note that the Lamber and Ogles (2004) figure does not distinguish between reliable deterioration and deterioration that is not reliable. Comparing the findings of the present study with Stiles et al (2006) it is apparent that the findings are more in keeping with this large data set where just over 1.25% of clients showed reliable deterioration.

In the present study some clients may have been deteriorating as a result of an ongoing crisis and it is unlikely that therapy or a therapist of any kind would have been able to stop such deterioration. Additionally, as noted in the literature review it is not uncommon for clients to report change in a saw tooth pattern (Stiles 2005). To determine whether the change recorded in session three was representative of overall outcome follow up data would be required. It may be possible to infer from the data that the change observed in this study after the third session was accurate as no significant differences were found between the scores on the CORE OM at session three for those who also went on to complete forms at session five. This finding suggests that clients’ reporting at session three was representative of session five progress also.

11.1.4 Effects of different therapeutic approaches
The literature review highlighted that there is much disagreement over the comparative effects of the range of therapies available in routine practice settings. In addition to this
Luborsky et al (2002) showed that the picture, even that painted by meta-analysis, is far from clear. The current study used a range of therapists providing different therapeutic approaches. These included person-centred therapy, cognitive behaviour therapy, solution focussed brief therapy and integrative/experiential therapy. When looking at the effect sizes using Cohen’s $d$ for each of the therapeutic approaches these ranged from 0.7 for person-centred and 0.8 for integrative/experiential to 0.9 for cognitive behaviour therapy and 1.1 for solution-focussed brief therapy.

All of the effects observed fall into the large effect size bracket, however, the significant difference observed between solution-focussed brief therapy and person-centred and integrative/experiential therapy may be explained by the difference in therapist effects as opposed to the effect of the different therapeutic approaches. For example, the results for solution-focussed brief therapy are taken from the contribution of a single therapist. Interestingly though, perhaps, this therapist was also the most experienced therapist taking part in the study with eighteen years of therapeutic experience. In contrast to a single therapist representing an approach the person-centred and integrative/experiential groups which showed smaller effect sizes were made up from ten different therapists and the data for these two groups consisted of sixty percent of the total data collected. Included in these approaches were a number of newly qualified and less experienced therapists together with five trainee therapists. Of the two more experienced therapists in these groupings one had six years experience and the other fifteen years experience.

The research into the effects of individual therapists has shown that some therapists are more effective than others (Lambert and Ogles, 2004; Miller, Hubble and Duncan, 2007; Orlinsky and Howard, 1980). There is also evidence to suggest that those therapists with
a more psychological as opposed to biological approach to the problem have better results (Blatt, Sanislow, Zuroff and Pilkonis, 1996). However, of interest to the findings of the present study, a meta-analysis of studies with varying degrees of differences between therapist effects carried out by Crits-Christoph and Mintz (1991) found that when level of experience was partialled out of the correlation between overall effects and individual therapists, more experienced therapists were found to produce smaller effects.

11.1.5 Specific or non-specific effects
The debate over specific or non-specific effects is a heated one. The present study did not set out to determine the effects of specific elements of the different therapies under observation. As a result there was no attempt to control for the different aspects and therefore no direct comparison can be made across approaches with regards to the different components of therapy. The study used the first three sessions of psychotherapy as the period in which change would be observed and as such it must be recognised this is a relatively small number of sessions in which to expect change to occur. It is, however, worth considering what the data produced in the present study can tell us about specific effects in psychotherapy. One of the arguments raised in the literature review suggests that in therapies that rely on specific interventions the specific elements for achieving change are not active in the first part of therapy and therefore other processes may be more dominant (Ilardi & Craighead, 1994; Vittengl, Clark & Jarrett, 2005). For example, early gains in this study were observed across the different therapeutic approaches regardless of the approach being used which is suggestive of non-specific factors being responsible for early changes in therapy. This finding is similar to that found in the TDCRP study data used by Zuroff and Blatt (2006) that
demonstrated that even after early gains were controlled the therapeutic relationship proved to be the most reliable predictor of outcome.

However, it is important to note that in a study such as this where data is collected using a naturalistic design the possibility of specific effects on outcome can not totally be ruled out in favour of non-specific effects. As the two therapists in the study who used either a CBT or solution-focussed approach were not following therapy manuals, it is quite likely that the specific elements of these therapies were available during the first three sessions and therefore may have contributed somewhat to the change observed in clients that received either of these therapies and may explain some of the larger effects in the CBT and solution-focussed brief therapy clients.

11.2 The Barrett-Lennard Relationship Inventory

11.2.1 General discussion for factor analyses of RI
In the present study it was decided to use a composite score for the RI when assessing levels of the therapeutic conditions. This decision was based on the findings of factor analysis. Prior to assessing the effects of the therapeutic relationship on outcome in the present study a factor analysis was performed using the data collected. The factor analysis for the present study was conducted using data collected from both client and therapist responses for the Other to myself and Myself to Other versions of the RI. In all cases the factor analysis used data collected after the third session. The third session was identified as this provided the client and therapist to develop fuller perceptions of one another. Also, many of the previous factor analyses that have been carried out have
asked respondents to answer the individual items in response to an existing and well
formed relationship (e.g. parent, spouse, partner etc.). In the results section the findings
of these analyses are presented and suggested no clear factor structure for the RI when
completed by clients or therapists in this study. Some researchers have found support
for the underlying four factor model (Barrett-Lennard, 1962; Cramer, 1986a; 1986b;
Leitaer, 1974 and Walker and Little, 1969). However, others have found that the RI loads
on a single factor (Blatt, 1996; Watson and Geller, 2005). Interestingly, with the
exception of the original study carried out by Barrett-Lennard (1962), those studies that
found support for the original four factor model proposed by Barrett-Lennard (1962)
collected data from non clinical populations. That is, they were collected from college or
university students in Australia, Belgium or the UK who were not specifically known to be
in receipt of psychotherapy. In addition to this, respondents in these studies used a
relationship with a close friend, romantic partner or parent on which to base their
responses to the RI. This is in contrast to when completing the RI within a clinical setting
and the relationship between client and therapist is the focus and has been formed for a
relatively short period of time. This latter point may explain the general finding in the
present study of mixed factors. That is, clients seemed unable to distinguish between
empathy, regard and genuineness.

It is worth considering how the apparent lack of ability in being able to distinguish
between the various relationship conditions can be explained. One possible explanation
for this is that clients are unable to accurately perceive the therapeutic conditions as
distinct from one another. This view was originally proposed by Truax (1966) and
provided the rationale for using independent observers in studies in order to assess the
effects of the therapeutic relationship on outcome. However, this rationale also suggests
that clients are unable to recognise the quality of the relationship-as-a-whole. Yet, this
does not seem to be the case as many studies, including this one, have demonstrated that when clients provide an overall rating of the quality of the therapeutic relationship there does seem to be a positive association with outcome.

The issue of accuracy of interpersonal perception has been highlighted by other researchers as worthy of exploration and consideration (Cooper, 2005; Laing, Phillipson and Lee, 1966). It seems that these researchers have suggested it is quite common for people to hold mis-perceptions of the other and may go some way to not being able to distinguish between the various therapeutic conditions within the relationship seeing each as indicative of a single general factor.

There are possibly other explanations for the findings. The items used in the present study were selected by taking every second item from each subscale in the order they appeared in the original RI. This was done for each set of items with positive or negative wording giving a total of eight items, four positively and four negatively worded, for each subscale. It is possible that selecting the items in this way weakened the underlying factor structure and general composition of the original RI. However, as the studies reported above have shown, there are only a very small number of items that appear to be high loading items across different studies. This suggests that different samples are more able to identify some items better than others and vice versa for different sample groups. It is difficult to know why the current sample was not able to distinguish between the various sub scale items, especially those scores taken from the therapist participants.

A final possible explanation for the findings presented in this study worth mentioning is the sample size for the present study is too small in comparison to the total number of
item responses under investigation. Bryman and Cramer (2005) have reported the number of participants to enter data is required to be five times the number of individual items in the measure and that the number of respondents needs to at least 100 (Gorsuch, 1983). As a result the general view tends to suggest that not a great deal of confidence should be placed of replicating in a later study the factor structure found in an analysis using a sample smaller than around 100 or where there is less than five respondents for each item (Bryman and Cramer, 2005). The scale used in the present study had thirty two items and only sixty five respondents completed the RI at session three. Even though it might have been possible to identify a factor structure reflective of the original RI in the present study, it would seem the results could be viewed as unreliable due to the small sample involved.

11.3 Therapeutic relationship

11.3.1 Quality of relationship experienced by clients
After determining that a composite score for the RI to be the most reliable measure of the therapeutic relationship a key aim in this study was to consider the effect of the quality of the therapeutic relationship on outcome. The therapeutic relationship was assessed from a number of perspectives that provided a significant amount of data for analysis. Rogers’s (1959) original hypothesis stated that the temporal pattern of experiencing the therapeutic conditions is suggestive of change in the extent to which the conditions are provided and received. Rogers (1959, p. 218) statement that the outcomes of therapy will show clients ‘perceive others more realistically and accurately’ and that they will ‘experience more acceptance of others’ has been supported by the data collected in the present study. Clients rating of their own feelings towards therapists increased over time suggesting they experienced more acceptance, empathy and
genuineness for the therapist. This also supports Wilkins (2000) suggestion of receiving the therapeutic conditions from clients. Wilkins (2000) has stated the phenomenon of having experienced unconditional positive regard from clients, especially towards the end of therapy when this seems significantly increasingly likely to happen. Wilkins refers to this as mutual experiencing of the condition of unconditional positive regard.

This finding also indicates there is little to separate the processes and the outcomes of psychotherapy when measuring either process or outcome using relational variables. In the literature review the case was made and suggested several models make theoretical claims that psychological distress is the result of unsatisfactory relational experience. This is the case whether referring to early relational experience within an infant-care giver dyad, those perceived on the interpersonal level or later relationships in adulthood. The findings that client ratings of the quality of therapeutic conditions both perceived and provided within the relationship increased on average over the first three sessions supports the view that receiving these conditions is associated with greater capacity to provide the conditions. This can be related to the notion that the relational context is dynamically shaped by the people involved and that creating a healthier relational environment can subsequently lead to experiencing lower levels of distress. This supports the argument put forward in the introduction that the relational context can be thought of as both at the aetiological root of distress and also, in part at least, the corrective process.

11.3.2 Quality of relationship experienced by therapists
The findings of the present study support those of a large number of previous studies (Gurman, 1977) that have shown therapists to be much poorer at predicting outcome via
their ratings of the therapeutic relationship. A likely explanation for this is the tendency towards a lack of variance within the scores therapists provide for their own ratings of the levels of therapeutic conditions they provide. The present study showed that clients and therapists tended to agree on the levels of conditions provided by clients with virtually no differences found between the average levels. This was the case following both the first and third session suggesting that therapists are able to accurately perceive the extent to which clients were offering the therapeutic conditions. Whilst there were virtually no differences between the group means, it should be noted that clients and therapist did not converge on their ratings as no significant correlations were observed.

However, therapists tended to rate the level of conditions they held towards the client as higher than that which clients perceived them therapists to be providing. This supports previous findings where clients and therapists ratings of the quality of the therapeutic relationship have not correlated (Barrett-Lennard, 1981; Gurman, 1977). In the present study client and therapist ratings of therapist provided conditions did not correlate. The lack of concordance between client and therapist ratings of therapist provided conditions may be explained by a number of factors. As stated above, mis-perceptions is one possible explanation. However, another explanation may be due to differences between interactional style of different therapists. More expressive therapists may be being perceived by clients as more understanding, accepting and genuine than less expressive therapists whilst both may be experiencing high levels of the therapeutic conditions. Alternatively, some clients may be less receptive to the therapeutic conditions being offered by therapists. As a result it is possible from this to deduce that it is the extent to which the therapeutic conditions are experienced by the therapist, received by the client and then reciprocated by the client and in turn subsequently built upon by the therapist which is the most reliable predictor of outcome. This argument supports the bi-directional

257
view of the therapeutic relationship conditions and provides the basis for developing mutuality.

11.3.3 Association between the relationship and outcome using CORE-OM
The hypothesis that the therapeutic relationship predicts outcome was partially supported in the present study. Client session one ratings of the therapeutic conditions provided by therapists significantly predicted session three outcome at the one tailed level. This finding of an association between the quality of the early therapeutic relationship and later outcome were in line with earlier findings. As others have previously found (Zuroff and Blatt, 2006) the therapeutic relationship is a reliable predictor of outcome when using a measure of the client’s perception of the therapeutic conditions provided by therapists. The present study found that when early levels of distress were controlled, the correlation between clients perceived early conditions and later outcome lost significance. However, this association remained close to significance suggesting that in a larger more powerful sample this finding would possibly have maintained significance meaning the therapeutic relationship again shows its ability to predict later outcome when controlling for early levels of distress thus rejecting the sceptical view that positive ratings of the therapeutic relationship are given as a result of the positive changes clients make.

In addition, the present study also assessed the extent to which the client’s own feelings towards the therapist within the therapeutic relationship were associated with outcome. The findings of the present study showed the extent to which clients understood, accepted and were genuine with their therapist was also related to outcome and met a level for significance ($p = 0.05$) at the one tailed level. However, some caution should be
taken when interpreting this finding as there was a high correlation between clients' rating of their own feelings towards the therapist and of the level of conditions clients perceived therapists were offering. The danger here is that these two variables may actually be measuring the same variable as the level of association between them surpassed that required for tests re-test reliability score. However, in light of the above findings from the factor analysis it would appear that different items loaded on different factors suggesting these two perspectives may indeed be measuring different yet closely related constructs. If the latter is correct this supports Rogers’s suggestion of the close association between process and outcome variables. As a result, the reciprocal nature of this finding need not be viewed negatively. Rogers (1959) stated that the relationship between the therapeutic conditions provided by the therapist and the client’s increasing experiencing of these conditions was indeed expected to be reciprocal in nature.

The findings from this study did not lend support to the suggestion that therapists are able to predict outcome. Therapist ratings of session one levels of the therapeutic conditions they provided to clients were not associated to outcome in session three. In fact, therapists were very poor at predicting the association between the quality of the therapeutic relationship and outcome. This finding is in keeping with earlier studies looking at the therapeutic relationship and outcome (Cramer and Takens, 1992; Gurman, 1977). This again returns us to issues raised over therapist ability to predict outcome using the RI. As suggested earlier, the theory proposed within the classical person-centred approach, and for which the RI was developed, it is the client’s perception of the therapeutic conditions which is expected to be the strongest predictor of outcome.
11.3.4 Summary
It would appear that the client’s view of therapist provided conditions at session one is a reliable predictor of later outcome and synchronous correlations at session three were also significant. In addition, the client’s own ratings of the level of therapeutic conditions they experience towards the therapist are also able to predict outcome. These two variables are likely to be closely interrelated, yet distinct, elements of the bi-directional relationship which exists between therapist and client. The finding that the client’s experiencing of the therapeutic conditions towards the therapist is associated with outcome supports evidence discussed in the literature review of a bi-directional pattern to the therapeutic relationship.
Chapter 12
Discussion
Mutuality and Outcome
12.1 Mutuality and Outcome

As much of the research in the literature review has suggested, mutuality is a key component of the therapeutic relationship (Aron, 1996; Rogers, 1959; Wilkins, 2001). A main aim of this study was to measure and test the effect of mutuality within the therapeutic relationship and to see whether this would predict outcome. It has already been shown that the therapeutic relationship at session three was most strongly associated with outcome at session three. This was the case when considering the client’s rating of the therapist provided conditions and client’s rating of their own therapeutic conditions towards the therapist. Therapist ratings of their own and the client’s therapeutic conditions at session three were not significantly associated with outcome at session three.

It is important in the next sections of the thesis to explore the findings from the analyses looking at mutuality to determine the implications for psychotherapy practice. For example, approaches to psychotherapy that consider the therapeutic relationship to be the so called curative factor are also implicitly relying on another factor – client perception. It was outlined in the literature review that Rogers (1957/1959) theory was based on the client’s perception of the therapeutic conditions. A number of studies were reviewed that showed, for example, when clients and therapists jointly experience the other as warm and accepting then outcomes are more positive. A key question raised in the literature review is whether clients can accurately perceive therapist empathy, unconditional positive regard and genuineness and their perceptions are tied to the actions, behaviours and intentions of the other (Laing, Phillipson and Lee, 1966). For example, it was also noted in the literature that clients are likely to perceive their
therapist as they see themselves yet much of the theoretical literature in relation to the
development of psychological distress has focussed on the reverse, that we are likely to
see ourselves in relationship as we see others. That is, with internalised conditionality,
for instance. In the analysis of mutuality it would seem important to not only consider the
extent to which a client perceives the therapeutic conditions from the therapist but also
to see how this is tied to the way that the therapist may see herself within the
relationship.

12.1.1 Mutuality of perceived therapist provided conditions.
Taking the understanding of mutuality to be the interaction between client and therapist
perception of the therapeutic conditions a number of permutations were considered
within the study. As a result the most effective test for mutuality in this design was a test
of moderation. The first test of mutuality to be considered was based on the mutual
experiencing of therapist provided conditions. As much of the research has suggested, it
is possible for the client to perceive the therapist as providing either high or low levels of
the conditions and the results above have shown that therapists tend to show little
variance in their rating of themselves as providing the therapeutic conditions. This study
aimed to see whether when clients and therapists jointly experience high levels of
therapist provided conditions that this has an effect on outcome.

The results appear to have supported this hypothesis. Hierarchical multiple regression
analysis showed significant interaction effects for therapist MO scores for the
relationship conditions on the relationship between client OS scores and client ratings for
CORE-OM. This finding lends moderate support for the notion of mutuality in
experiencing the therapeutic conditions demonstrated within the client-therapist

263
therapeutic dyad. The finding suggests that the correlation between outcome and client OS scores is strongest when therapists also rate themselves as providing high rather than low levels of the therapeutic conditions. The finding that mutual levels of therapist provided conditions is important and may go some way to explain various anomalies in earlier research findings. For example, it has been reported that many of the findings that have failed to show a reliable association between therapist’s MO rating of the therapeutic conditions and outcome may indeed have been due to a lack of variance in therapist’s ratings of themselves (as suggested by Gurman 1977). The findings in this study showed that therapist ratings do vary and once having been divided into two groups for high and low levels of the conditions it was possible to show an interaction between these scores and the association between client ratings and outcome. In doing so this seemed to highlight the effects of mutuality. From this analysis it seems that the association between client’s rating of the therapeutic conditions provided by the therapist (Rogers original hypothesis) cannot be seen as totally independent of the therapist’s view of the therapeutic conditions they are providing. This is because it seems this association is stronger when the therapist’s own experience of being genuine, empathically understanding and unconditionally accepting is high rather than low.

When therapists and clients rate therapists as providing low levels of the conditions then scores on the CORE-OM are at their highest meaning distress is higher. This finding is notable as one of the key findings from the factor analyses was the identification of negative feelings by both client and therapist. The point that clients are able to identify negative feelings in therapists, and when therapists also openly report this is a notable one. This supports the findings of Hill et al (1996) that when clients identified the negative feelings of the therapist and therapists were aware of and matched these negative feelings towards the client then outcomes were poorer. The same seems to
have been the case in the present study. Mutually low levels of perceived therapeutic conditions were associated with poor outcome.

Other researchers (Cramer and Jowett, 2009) have found that perceived empathy was significantly negatively associated with distress; the moderator results in this study also suggest an important role for accurate empathy in the outcome of psychotherapy. Accuracy here is referred to as the agreement between client and therapist perception of the therapeutic conditions. It is important to consider what this means for practice and theory alike. From a theoretical point of view it appears to support the view originally proposed by Rogers (1957/59) that the therapeutic conditions can be mutually experienced and this leads to positive change. Likewise, this finding supports the view that how the therapist and client feel towards one another is also important factor. However, this does not mean that they essentially feel the same towards each other (Aron, 1996). Rather, it may be that whilst the therapist is focussed on client experiences in their empathic reflections and unconditional positive regard clients are similarly focussed on the therapist’s experience of the client experience.

McMillan and McLeod (2006) suggested that during meeting at relational depth within therapy clients and therapists may have very different experiences and to some extent use this evidence as a means for discrediting the role of mutuality. However, their description of the client’s focus on ‘self’ during the therapeutic moment locates the client’s self as separate and distinct from the therapist. As the research in this study has shown it may not be possible to draw clear distinctions between perceptions of self and other and the ways they are distinct or related to one another. Another explanation for the findings here and those of McMillan and McLeod (2006) is that whilst the therapist focus of attention is indeed the client, the client’s focus of attention can also be the client
self and that this may be being experienced by the client as self-experience-of-self or as
the self-experience-of-therapist-experience-of-self. Rather than the focus of attention
being located within each individual, the focus of attention for understanding mutual
experiencing is in the self as experienced within the relational field.

In considering the finding of the mutuality of perceived therapist provided conditions it is
also worth exploring what may actually be happening with regards to the content of
those perceptions. For example, it has been stated that mis-perception can be the cause
of much interpersonal dysfunction and lead to significant psychological distress (Laing,
Phillipson and Lee, 1966). It may be helpful to use a hypothetical example to highlight
what is implied within the results. For example, take an instance when a client who
experiences low self worth much of the time and in therapy generally experiences the
therapist as warm, accepting and understanding. At times the client experiences the
therapist's experience of the client as not matching what they say. That is, the therapist
says warm things but the client perceives a lack of consistency in this feeling. This
causes the client to feel marginally worse than before, confirms their perceived low self
worth and now feels a little less willing to be open with the therapist. This implies
mutually low levels of the therapeutic conditions. However, at times the client perceives
the therapist's perception of the client as someone of true worth which results in the
client experiencing greater self acceptance and reciprocal warmth towards the therapist.
This implies mutually high levels of the therapeutic conditions and highlights the findings
explored in this section of the discussion. The client’s focus of attention is located both at
the intrapersonal and interpersonal level.

Finally, and in addition to this, the finding above suggests that despite initially showing a
weak association between therapist ratings of the quality of the therapeutic relationship
and outcome the therapist’s perspective remains an important factor in predicting outcome. Also, further analysis of the moderating effects of such variables should be carried out on those findings obtained in studies that initially suggest little or no association. From these analyses it would appear that a helpful way to define, measure and test the mutuality hypothesis within the therapeutic relationship is to consider the extent to which the association between client perception of therapist conditions and outcome is moderated by therapist experience of the therapist providing the relationship conditions.

12.1.2 Mutuality of perceived therapist and client provided conditions.
It was outlined earlier in the thesis that the second method for defining mutuality within the therapeutic relationship was to assess the extent that client and therapist experience each other as providing the therapeutic conditions to one another. This way of considering mutuality is more in keeping with the dialogical and intersubjective views offered by contemporary person-centred perspectives and relational psychoanalysis and relational/cultural therapy respectively. However, in terms of Rogers’ (1959) theory this may be more closely aligned with what he referred to as reciprocity and though Aron (1996) suggested the terms mutuality and reciprocity have different meanings the findings from this study suggest both may be related to outcome.

The second analysis for mutuality explored the moderating effect of therapist perception of client provided conditions on the association between the client rating of therapist conditions and outcome. The findings from hierarchical linear multiple regressions again showed a significant interaction effect and once plotted the interaction terms suggested a similar finding to that discussed above. Client rating of therapist conditions and
outcome were more strongly associated in the group of high therapist ratings of client provided conditions than were the low group.

The concept of clients experiencing the therapeutic conditions towards the therapist is a contentious issue. For example, it has always to be remembered that therapy is for the client. However, it appears from the findings in this study that the extent to which a therapist perceives a client as holding these conditions towards them has an effect on the association between the client’s perception of the therapist and outcome. This may make more sense than one might first assume. Rogers (1959) suggested that in the outcomes of psychotherapy the client more accurately and realistically perceives the other person and ‘experiences more acceptance of others as a result of less need for distortion of his perceptions of them’ (Rogers, 1959 p.218). As a result it is reasonable to see how the extent to which the therapist is able to offer unconditional positive regard is affected by the way the client mutually experiences these feelings towards the therapist.

Rogers draws no distinction between process and outcome in psychotherapy and it is possible from what is described above to see how the results in the present study support the views offered by Laing, Phillipson and Lee (1964) and those of Rogers (1959) that as therapy progresses and there is less distortion, more authentic relationships are developed on the basis of accurate perception and mutuality. Rogers seems to use the terms reciprocity and mutuality synonymously in his writing and so it is not entirely clear what he meant. However, Aron’s (1996) description suggests that mutuality incorporates reciprocity but is perhaps a higher order construct. The results in the present study neither confirm nor deny this idea, however, it is clear that both approaches to understanding mutuality produced significant interactions through a test of moderation.
12.1.3 Implications for practice
There are important implications when considering these findings from the perspective of psychotherapy practice. For example, some therapists may tend to think they are providing high levels of the therapeutic conditions when in fact the client is experiencing them differently. It could be the case that simply because therapists perceive themselves as holding high levels of the therapeutic conditions they are less likely to pay attention to the meta-perception of this. That is, their perception of how the client is experiencing them in relation to being genuine, accepting and understanding. Attention to this process is obviously a key factor in all therapeutic work. However, it is possible that not all therapists are paying close enough attention to this intersubjective process within the therapeutic relationship. Therapists may do well to strive to develop this in their work to enhance the accuracy of their perception and experiencing of the relationship conditions in order to facilitate positive change within clients. It would seem from this that when therapists perceive themselves as providing high levels of the therapeutic conditions the association between the level at which clients perceive these to be present has a significantly stronger association with outcome.

The finding that the client’s view of the therapist and vice versa is very highly correlated has significant implications for the practice setting. In the main therapists practice from the assumption that their empathic understanding and acceptance of the client is experienced and provided to the client irrespective of the client’s view of the therapist. The findings from this study suggest that client’s views and attitudes matter very much and shape the way that therapists are seen by their clients. As a result, it is essential that therapists not only have an awareness of the intersubjective processes outlined
above but also consider their perception of the client’s attitude towards them. Any indication that the client senses therapist deference for example, will inevitably shape their perception of the therapist’s empathic understanding and acceptance. For this reason, in the practice setting it is essential that therapists consider how they both perceive the client and how they perceive the client feels towards them.

Following on from this an interesting finding with implications for practice is that outcome seemed to be worst when client perceptions of therapist provided conditions is low yet therapists rate themselves as providing high levels of the relationship conditions. That is, when there is a mismatch between how clients and therapists perceived the levels of therapeutic conditions being provided scores on CORE-OM were highest. This could be interpreted as meaning, with regards to mutuality of experiencing the core conditions, agreement and accuracy of the availability of the conditions may be more important than the actual level of conditions being provided. That is, mutuality is also a predictor of outcome independently to the level of therapeutic conditions being provided. This would be an important theoretical development with regards to that originally proposed by Rogers (1959) which stated that client changes were reliant on the levels, that is the extent to which, the client perceives the conditions. The findings here indicate that agreement and level may be important factors.

The notion that mutuality in perceived therapeutic conditions is important for achieving positive outcomes is important and that a mismatch is detrimental is equally important. One strategy that can be applied within the practice setting as a result of this finding is for clients and therapists to reflect on their perceived levels agreement in the extent to which they are mutually experiencing the therapeutic conditions. In this sense the therapeutic relationship between client and therapist becomes the foreground of any
therapeutic work and may lead on to working through any mismatch that may exist. This process of working through will potentially lead to developing mutuality of the relationship conditions and may even provide enough data for the therapeutic process to occur. This focussed working through of relational dynamics within the therapeutic setting makes for an intense therapeutic environment and would need to be addressed sensitively by the therapist so as not to reinforce difficult or problematic relational schemas that lead to the client attending therapy in the first instance.

In taking this forward it is necessary to consider what steps practitioners can take towards enhancing the therapeutic experience. For example, some clients may continue to deteriorate if mutually low levels of client perceived therapist provided therapeutic conditions persist unacknowledged by the therapist. This would be contrary to what both client and therapist intended to gain from therapy. The issue of therapists addressing the issue of mutuality within the therapeutic relationship with the client may even be present from the first moments therapeutic work begins. For example, from a person-centred perspective Wilkins (2005) has suggested that person-centred practitioners should use assessment procedures to determine whether they are able to offer the six therapeutic conditions to clients. The results in this study suggest that if a therapist feels as though they are unable to offer a client satisfactory levels of the therapeutic conditions then this may well have detrimental effects for the client with regards to outcome. This finding is in contrast the often cited claim that non-directive therapy can be conceived as a relatively benign phenomenon as long as no abusive acts are perpetrated. However, the findings in the present provide evidence which suggests that more dynamic factors are at work with regards to perceptually low levels of the therapeutic conditions having detrimental effects on client wellbeing. The findings that clients do worst of all when therapists consider themselves as providing high levels of the conditions and clients rate them as
providing low levels of the conditions has some serious implication for those studies that have used non-directive or ‘supportive’ psychotherapies as controls for comparative randomised controlled trial research. It is relatively well noted that researcher effects can influence the outcomes of such trials, and yet supportive therapies still tend to do well. However, it may be that these therapies are actually even more effective as many of the RCT studies do not use therapists committed to this approach and to working on the relational dynamics at play. When this is the case, the findings from the present study suggest that this can lead potentially lead to client deterioration.

One area the present research findings may have implications for practice is whether it is appropriate to foster interventions that are directed at facilitating interpersonal relational processes or whether this is something that naturally occurs through a more traditionally oriented client-centred psychotherapy. This is an area of work that has caused significant debate within the person-centred experiential field. However, it would seem from the literature reviewed in the introduction, the findings from the results of the present research study that a focus on interpersonal processing may actually be beneficial for clients in alleviating distress and may also help the therapist to provide increasingly higher levels of the therapeutic conditions that are subsequently more accurately attuned to the client’s own perception of the therapist.

12.2 Reflection on conducting the study
The topic that has been the focus of this study emerged from just under a decade of clinical practice as a psychologist working as counsellor and psychotherapist. During this time I learned that it was far easier to relate to some of the clients that I worked with than others and this seemed to hold true regardless of what I tried or believed that I was able
to offer to them. Reading around the various texts that Rogers left as his legacy it seemed to me that much of his theoretical propositions were largely based on what he termed reciprocal or mutual process.

To me this seemed at odds with what researchers had done after Rogers himself had ceased to study individual psychotherapy. These later researchers seemed to be intent on demonstrating effectiveness and less concerned with exploring their own experiences within therapy and developing theory through such endeavour. The research designs used in studies examining the effects of the relational components of psychotherapy had mainly adopted the methods associated with a ‘drug metaphor’ suggesting that it is the amount of genuine empathy and acceptance a client perceives that is key to therapeutic success. Putting all these aspects together lead me to the conclusion that the most significant, yet absent from the research, aspect of client-centred therapy is the client. I decided to explore the experience of the client and they way they felt towards the therapist to see if this had any connection with outcome.

Carrying out a study of this nature was a deeply challenging process not least because it was clearly going in the opposite direction to the research that had been carried out before. Until this study, research exploring the person-centred concept of the therapeutic relationship has ubiquitously been focussed on what the therapist does to or feels for the client. This study turns this on its head and considers what the client feels for the therapist in addition to what the therapist feels for the client. Taking on a study so at odds with the literature created significant anxiety. At times this was proved to be not solely attributable to paranoia as some colleagues and/or associates indicated their view of this hypothesis as a fruitless one. There were however, people who responded with enough genuine interest and enthusiasm for me to persist. As a result I am pleased to
say that the study has made a truly original contribution to the research literature in the field of relationship based research within psychotherapy.

It is reasonable to question why I selected a quantitative design for this study. I was keen to carry out a study of the therapeutic conditions identified by Rogers (1957) as necessary and sufficient for successful psychotherapy. These conditions have been most frequently researched using the B-L RI and prior to this study provided the most theoretically consistent measure available. On reflection, this tool may not have been the most sensitive to mutual experiencing of the therapeutic conditions. Having completed the study I would now recommend that a new measure be designed that specifically measures the mutual experiencing of these conditions. However, prior to doing this, I would also suggest that this research has showed me that one must be cautious before moving too quickly towards a quantitative methodology. As is suggested above, I would recommend further study using qualitative methods in order to clearly define the experience of mutuality within the person-centred therapeutic relationship. The findings from these future studies can then be used to develop a quantitative measure of mutuality.

The experience of having completed this study has impacted upon my practice as a psychotherapist in several ways. For example, as a practitioner I am now more open to the exploration of my client’s experience of me, as another person, within the therapeutic relationship. The stance of the psychotherapist is, in terms of traditional convention, one where it is the client’s material that always is the focus of psychotherapy. This study has not entirely changed that view although, it has to be said that this view has been challenged. For instance, if interpersonal relating is part of what it means to be a human being, then it is essential for the client to have the opportunity to experience being fully
human within the therapeutic relationship. This view, in holding the spirit of mutuality, has to consider the notion there may be times when the client has as their focus the therapist's experience rather than their own. This is a truly challenging prospect for the practice of psychotherapy and one that challenge what this might imply on my own future practice. However, before making significant or quantum shifts to practice, I believe that further research is necessary.

12.3 Limitations of the present study
There are a number of limitations to the present study that need to be considered. These can be grouped under the two main headings of measurement and sampling. First it should be noted that the design of the study meant using self report questionnaire data with a shortened version of the B-L RI. The method with which the items were selected could have been responsible for the lack of support for the four factor structure the RI claims to assess. As a result this meant it was not possible to test for the different relational components of the therapeutic relationship. For example, it would have been interesting to look at the ways that specifically empathy and positive regard are experienced mutually and reciprocally within the relationship. As a result of this only the whole relationship was assessed with regards to mutuality.

One question with regards to the use of the RI is it aims to capture the level of perceived therapeutic conditions. However, as is noted in the discussion above therapists may perceive themselves very differently within the therapeutic relationship than do clients. The RI does not aim to capture the accuracy and content of the therapist's perceptions of the client. Likewise, clients are susceptible to perceptual errors and therefore may not
be assessing the way that therapists feel about them accurately at all – as is shown above this can be the cause of much distress especially it would appear if therapists view themselves as providing high levels and clients don’t. What would be helpful is a measure that not only captures the level of empathy, unconditional positive regard and genuineness but is also able to capture the content of the empathy, the parts of the client that are unconditionally accepted and how genuineness is enacted within the therapeutic relationship. This would lead to the development of a scale for mutuality and reciprocity within the therapeutic relationship.

One issue that is in need of mentioning at this point is the high level of correlation between the different vantage points that each member of the therapeutic dyad was asked to rate the relationship from. For example, it could be argued that clients rated the level of therapeutic conditions they perceived therapists provided based on the way they themselves felt and subsequently rated their own level of conditions towards the therapist. Likewise, therapist rating of how they perceived the client felt towards them was very highly correlated with the level of therapeutic conditions they provided to the client. These variables correlated at such a high level it can be argued that they may actually be measuring the same construct. In defence of this potential shortcoming is the point that by simultaneously entering the data for these two different perspectives the factor analysis showed that the items appeared to load on a sufficiently broad spread of different factors suggesting that these are possibly distinct but highly related constructs. This latter point would fit more with the theory suggested by Rogers when he discussed the very thin line between therapy process variables and measurable outcome variables. This seems especially pertinent when considering the therapeutic conditions of empathy, unconditional positive regard and congruence.
The current study entered data for sixty five clients at session three for the RI, as such this small number of respondents in relation to the number of items may have been a greater issue with regards to using factor analysis. The sample size for the whole study was significantly reduced by the nature of the design. For example, the commitment to collecting data from bona fide psychotherapy sessions meant it was incredibly difficult to attract participating therapists and even though two services were recruited only one continued to collect data for the duration of the study. The second withdrew due to the internal issues of the organisation. The sample size will have undoubtedly weakened the power within the statistical analyses. However, to have even obtained some degree of significance with the current sample is impressive and a larger sample would likely have produced greater significance. Recruiting and retaining participants in psychotherapy research is notoriously difficult and as a result the findings of this study are limited by the sample size.

12.4 Suggestions for future research
The present study has highlighted the role of mutual experiencing of the therapeutic conditions – from both the perspective of how the client and therapist perceive the therapist alone feels towards the client and from the perspective of how the client and therapist perceive one another as feeling to the other. The study attempted to do this by using data collected through self report questionnaires. It was identified that by separating therapists into groups that perceive either high or low levels of the therapeutic conditions that significant interactions were observed. Further studies will possibly benefit from using qualitative methods in an attempt to further understand the phenomenology of ‘living’ in therapeutic relationship that is experienced as being viewed as either mutual or non mutual.
This could be done by using the methods used in the present study to identify therapeutic dyads and take a purposive sample and follow up with in qualitative analysis. For example, it would be valuable to have DVD of audio recording of sessions from those therapeutic relationships that were identified in the present study as high or low in mutual experiencing of the therapeutic conditions. Using DVD footage would be an excellent way to see what the behavioural markers of mutuality are or where therapist behaviour does not necessarily match with the level of therapeutic conditions recorded using the RI.

With regards to developing theory the present study has highlighted the association between mutuality of the therapeutic conditions and outcome. It now seems necessary to further understand how mutuality is developed within the therapeutic relationship and whether there are associations between the mutual experiencing of the therapeutic conditions and other bi-directional constructs such as the real relationship or the therapeutic alliance. One final area of research would be to explore the association between mutuality and other related theoretical concepts such as relational depth.

**12.5 Conclusion**
The present study has attempted to explore the role of mutuality within the therapeutic relationship with regards to facilitating positive change. The quality of the therapeutic relationship was only weakly associated with outcome in session three when assessed by clients. Therapist rating of their own therapeutic conditions continues to be a poor predictor of outcome and no significant correlation was found between these variables in the present study. Each of these, however, is rooted in the traditional conceptualisation
of the therapeutic relationship as a one system of delivery of the therapeutic conditions. When considering the way that mutual levels of the therapeutic conditions are experienced within the relationship significant interactions were found. These were from the perspective of client and therapist mutuality of therapist provided conditions and for client and therapist perception of the therapeutic conditions provided by the other. As a result the association between client ratings of therapist provided therapeutic conditions and outcome is strongest when therapists perceive themselves to be providing high rather than low levels of the conditions and when they perceive the client to be reciprocally providing high rather low levels of the therapeutic conditions.
References


Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that “Everyone has won and all must have prizes”? *Archives of General Psychiatry, 32*, 995-1008.


*Person-Centered & Experiential Psychotherapies*, 9, 52-68.


Appendix 1

Relationship Inventory: Forms MO and OS
**RELATIONSHIP INVENTORY** (Adapted from B-L R I)

<table>
<thead>
<tr>
<th>Client Ref:</th>
<th>Date:</th>
<th>Gender: M / F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist ID</td>
<td>Session No.</td>
<td></td>
</tr>
</tbody>
</table>

Below are listed a variety of ways that one person may feel or behave in relation to another person. Please consider each statement with reference to your counselling/therapy relationship. Circle a score for each question according to how strongly you feel it is true or not true in this relationship.

Please give a mark for every statement. Circle either, 1, 2, 3, 4, 5 or 6 to stand for the following answers:

1 = No, I strongly feel that it is not true
2 = No I feel it is not true
3 = No, I feel that it is probably untrue, or more untrue than true
4 = Yes, I feel it is probably true, or more true than untrue
5 = Yes I feel it is true
6 = Yes I strongly feel that it is true

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I respect them as a person.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I want to understand how they see things.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>My interest in them depends on what they say or do.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I am comfortable and at ease in our relationship.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I understand their words but I do not understand the way they feel.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Whether they feel happy or unhappy with themselves makes no real difference to the way I feel about them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I feel that I put on a role or a front with them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I am impatient with them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I feel appreciation toward them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I usually sense or realise what they are feeling.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I want them to be a particular kind of person.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I nearly always feel that what I say expresses exactly what I am feeling and thinking as I say it.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I find them rather dull and uninteresting.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>My own attitudes towards some of the things they do or say prevents me from understanding them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>They can (or could) be openly critical or appreciative of me without really making me feel any differently about them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I want them to think that I like them or understand them more than I really do.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I just tolerate them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I usually understand the whole of what they mean.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>If they show that they are angry with me, I become angry with them, too.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>I express my true impressions and feelings with them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>I am friendly and warm with them.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I just take no notice of some things that they think or feel.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>How much I like or dislike them is not altered by anything that they tell me about their self.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>At times they sense that I am not aware of what I am really feeling with</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I am openly myself in our relationship.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26</td>
<td>They seem to irritate and bother me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27</td>
<td>I do not realise how sensitive they are about some of the things we discuss.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28</td>
<td>Whether the ideas and feelings they express are 'good' or 'bad' seems to make no difference to my feeling toward them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29</td>
<td>I understand them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30</td>
<td>Sometimes they are more worthwhile in my eyes than they are at other times.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31</td>
<td>I am truly interested in them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32</td>
<td>What I say to them often gives a wrong impression of my whole thought or feeling at the time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Below are listed a variety of ways that one person may feel or behave in relation to another person. Please consider each statement with reference to your counselling/therapy relationship. Circle a score for each question according to how strongly you feel it is true or not true in this relationship.

Please give a mark for every statement. Circle either, 1, 2, 3, 4, 5 or 6 to stand for the following answers:

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>They respect me as a person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>They want to understand how I see things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Their interest in me depends on what I say or do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>They are comfortable and at ease in our relationship.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>They understand my words but do not understand the way I feel.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Whether I am feeling happy or unhappy with myself makes no real difference to the way they feel about me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>I feel that they put on a role or a front with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>They are impatient with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>They feel appreciation toward me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>They usually sense or realise what I am feeling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>They want me to be a particular kind of person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>I nearly always feel that what they say expresses exactly what they are feeling and thinking as they say it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>They find me rather dull and uninteresting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>Their own attitude towards some of the things I do or say prevents them from understanding me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>I can (or could) be openly critical or appreciative of them without really making them feel any differently about me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>They want me to think that they like me or understand me more than they really do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17</td>
<td>They just tolerate me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>They usually understand the whole of what I mean.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19</td>
<td>If I show that I am angry with them they become angry with me, too.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20</td>
<td>They express their true impressions and feelings with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21</td>
<td>They are friendly and warm with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22</td>
<td>They just take no notice of some things that I think or feel.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23</td>
<td>How much they like or dislike me is not altered by anything that I tell them about myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24</td>
<td>At times I sense that they are not aware of what they are really feeling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>25</td>
<td>They are openly their self in our relationship.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26</td>
<td>I seem to irritate and bother them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27</td>
<td>They do not realise how sensitive I am about some of the things we discuss.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28</td>
<td>Whether the ideas and feelings I express are 'good' or 'bad' seems to make no difference to their feeling toward me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29</td>
<td>They understand me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30</td>
<td>Sometimes I am more worthwhile in their eyes than I am at other times.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31</td>
<td>They are truly interested in me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32</td>
<td>What they say to me often gives a wrong impression of their whole thought or feeling at the time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix 2

Client information and consent form
What’s involved if I take part in the study?

- You and your counsellor will need to complete a questionnaire at the end of session 1, 3 & 5.
- As client, your CORE data will also be used for the study.
- All of the information you provide will be kept confidential by the research team from Loughborough University.
- The information you provide will be kept in a secure place and all identifying features will be removed, ensuring that you will remain anonymous.
- If you do take part in the study, and then change your mind you can withdraw from the study at any time and this won’t affect your access to counselling or psychotherapy, not now or in the future.

To withdraw from the study, simply let your counsellor know you no longer wish to continue.

The findings of the study may be used for educational purposes. If they are, there will be no way of linking you and your responses in anything that is printed or published.

What to do if you have any questions?

- If you have any questions about the study please ask your counsellor or psychotherapist or the named contact person at the counselling centre.

The principle researcher is

D.Murphy@lboro.ac.uk

Informed Consent Form

This study has been approved by the ethics committee at Loughborough University. I have read the information sheet and have had the opportunity to ask questions. I accept and understand that I am not obliged to take part in this study and that I may withdraw at any point without an explanation. I also understand that if I withdraw it will not affect the services I receive in any way.

I agree that the information I provide in the research study and the CORE data for the Counselling Service can be used for the research study, conference presentations, printed articles and published journals or books. I accept that all reasonable steps will have been taken to protect my anonymity and that any publication or dissemination of the data will be done so anonymously.

I give my informed consent to participate in this research study.

Signed……………………
Date……………………
Print
Name……………………………………
Age……………………..
Gender……………………
Ethnicity
1. White British  2. White Irish  
3. Other White
4. Asian or Asian British Indian
5. Asian or Asian British Pakistani
6. Asian or Asian British Bangladeshi
7. Other Asian or Asian British
8. Black or Black British Caribbean
9. Black or Black British African
10. Other Black or Black British
11. Chinese  12. Other
13. Asian (Bangladeshi)
14. Asian (Indian)
15. Asian (Pakistani)
16. Asian (East African)
17. Asian (Chinese)
18. Black (African)
19. Black (Caribbean)

Psychotherapy as mutual encounter: A study of relationship conditions

You are invited to take part in a research study, below is some information about the study and a consent form.

What’s the study about?

- The study is exploring the relationship between a client and their counsellor/psychotherapist.
- The study aims to see if the quality of this relationship has an effect on outcome.
- The study wants to find out more about some of the characteristics of this helping relationship.