Clients' experiences of cognitive restructuring techniques:

A tape-assisted recall study

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has

been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

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Date: 17/06/2014

Overview

A large body of empirical evidence demonstrates the effectiveness of Cognitive Behaviour Therapy (CBT), however there are gaps in our knowledge regarding the mediators and mechanisms of change in CBT. This thesis examines the kinds of experiences clients have in therapy, in order to gain a better understanding of the process and mechanisms of CBT.

Part One is a qualitative meta-synthesis of clients' retrospective accounts of their experiences of CBT. Part Two is a qualitative study which examines clients' experiences of therapist verbal responses in the delivery of cognitive restructuring techniques. It used Tape Assisted Recall (TAR) methodology to examine clients' moment-by-moment perceptions. Finally, Part Three is a critical appraisal of the research process in which the challenges of synthesising and appraising qualitative studies, the TAR methodology and researcher reflexivity are discussed.

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Part 1: Literature Review

A meta-synthesis of client experiences of individual cognitive behavioural therapy

Abstract

Aim: Despite being the treatment of choice for many psychological disorders, there are still gaps in our understanding of the process and experience of CBT. This paper aimed to conduct a meta-synthesis of clients' perspectives of CBT, in order to investigate these gaps and to contribute to a cumulative knowledge base concerning clients' experiences of therapeutic processes in CBT.

Method: Nine qualitative studies that examined clients' experiences of individual CBT met the inclusion criteria for the review. Methodological appraisal of the studies was conducted and the findings were synthesised using thematic analysis.

Results: The meta-synthesis generated ten themes which were clustered into three domains: "Technical aspects of CBT", "The therapeutic relationship" and "The therapeutic journey: from doubt to belief".

Conclusion: The meta-synthesis showed that clients value both the technical and relational aspects of therapy, suggesting that both are important ingredients of change. A possible direction for future research is to specify the interrelationships between these factors to provide a more fine-grained understanding of the ingredients of effective therapeutic interactions.

Introduction

CBT is the treatment of choice in the National Health Service in the UK for a range of psychological problems, including depression and anxiety (NICE, 2004, 2010). It is the most widely practiced of the psychotherapies, and has a large body of evidence supporting its efficacy (Hollon & Beck, 2013). However, there are still gaps in our knowledge regarding the mediators and mechanisms of change in CBT, i.e. why, how and for whom CBT works; these questions which have become the focus of psychotherapy research in view of their implications for developments in psychological interventions (Hollon & Beck, 2013).

Discussion about change mechanisms in CBT cannot be divorced from one of the most fiercely contested debates in the wider psychotherapy literature: the "specific versus common factors debate" (Asay & Lambert, 1999; Chambless, 2002; Wampold, 2001). Proponents of the common factors position argue that it is the factors that are common to all therapies, such as relationship and expectancy factors as opposed to practices specific to therapeutic orientations, which are primarily responsible for positive therapeutic change (Asay & Lambert, 1999; Wampold, 2001). This argument is predominately based on the paradoxical finding that the outcome of technically diverse therapies is roughly equivalent (known as the "Dodo bird verdict"; Rosenzweig, 1936, cited in Stiles, Shapiro & Elliott, 1986). The opposing view is that the specific factors unique to the different psychotherapeutic modalities are the active ingredients of change, based on the finding that some therapies are more effective for certain types of psychological distress than others (Chambless, 2002).

More and more, researchers and clinicians have moved away from taking such polarised positions, and there is an increasing recognition that both common

and specific factors contribute to change. Therefore, it is argued that what is more helpful for therapists and ultimately clients is to focus our energies on specifying the ingredients of change, and clarifying the mechanisms by which they effect change (Castonguay & Beutler, 2006; Cooper, 2008).

There is a growing evidence base for the factors that bring about change in CBT, particularly focusing on the technical and relational aspects of the therapy. Regarding the former, exposure, defined as "purposefully invoking anxiety by direct confrontation with the situations that produce fear in the patient" (Abramowitz, 1996, p. 584), has been shown to be highly effective in the treatment of anxiety disorders (see Abramowitz, Deacon & Whiteside, 2010 for an overview). Moreover, it has been found to have greater efficacy than other CBT techniques (Scholing & Emmelkemp, 1993). Similarly, behavioural activation has been shown to be effective (see Mazzucchelli, Kane & Rees, 2009 for a review), and it has been shown to be as or more effective than cognitive therapy in the treatment of depression (Jacobsen et al. 1996; Martell, Addis & Dimidjian, 2004).

Cognitive techniques and their association with outcome in CBT is probably the most debated of all questions in CBT. Some studies demonstrate that application of cognitive techniques is associated with positive outcomes (Dickerson, 2000), whereas a significant body of research shows that symptom improvement in CBT is unrelated to the application of cognitive techniques. For instance, the study by Jacobsen et al. (1996) showed that there was no change in effectiveness with the addition of cognitive techniques to a behavioural programme, and some studies have shown that symptom change in therapy precedes the application of cognitive techniques (Hayes, 2004). These findings cast doubt on whether cognitive techniques are mechanisms of change (see Longmore & Worrell, 2007). This is highly

contentious, given that within a cognitive model, cognitive change is proposed as a fundamental process in the alleviation of psychological distress (Beck, 1970; DeRubeis, Tang, & Beck, 2001), and cognitive restructuring has been identified as a hallmark that distinguishes CBT from other therapies (Blagys & Hilsenroth, 2002).

Research into the mechanisms of change in CBT has focused primarily on the techniques of CBT, whilst relational factors have, comparatively, received less attention. Despite a common misconception that relational factors are viewed as irrelevant in CBT (see Cooper, 2008), the importance of the therapeutic relationship is highlighted in some of the earliest writings about cognitive therapy (Beck, Rush, Shaw & Emery, 1979), and there is some evidence that suggests that the relationship is predictive of outcome (Gaston, Thompson, Gallagher, Cournoyer & Gagnon, 1998; Klein et al., 2003). However, there is ongoing discussion about the extent to which the therapeutic alliance facilitates change, and whether a strong client-therapist relationship is at least partially the product of symptom change (DeRubeis, Webb, Tang & Beck, 2010).

In terms of the kinds of relational factors that have been shown to be associated with positive outcome in CBT, Keijsers, Schaap and Hoogduin (2000), in their comprehensive review, identified two clusters of therapist interpersonal behaviour associated with positive outcome: the first related to therapist variables of empathy, non-possessive warmth, positive regard and genuineness, and the second to the therapeutic alliance, i.e. therapist and client agreement on the goals of treatment, and the quality of the bond between them (Bordin, 1979). There is debate, however, regarding the extent to which these factors influence outcome; some researchers have suggested that the therapeutic relationship accounts for as much as 30% of the

variance in outcome (Lambert, 1992), whereas in a recent review, Beutler et al. (2004) put forward a far more modest figure of between 7 and 17%.

The majority of research into mechanisms of change summarised thus far is quantitative research: randomised controlled trials in which CBT is pitted against another psychotherapy approach, or component analyses in which separate components of CBT are delivered to different groups to delineate the most efficacious therapeutic elements (see Longmore & Worrell, 2007, for a review). Other commonly used designs include regression analysis studies, which identify the extent to which treatment outcome is attributable to components, and more recently innovative methods such as growth curve modelling, to model trajectories of change over time (Laurenceau, Hayes & Feldman, 2007). However there is controversy about the extent to which these provide conclusive evidence for mediators and moderators of change.

Qualitative methods provide another avenue by which to explore the process of change in psychotherapy, by finding out about the kinds of experiences that clients have in therapy. They enable the in-depth study of client subjective experiences and therefore they are suited to explore the complexity of the therapeutic process in a way that quantitative methods are not (McLeod, 2013). Client experiences have traditionally been neglected in the literature (Campbell, 2007) because of a longstanding belief that clients are biased and unable to recall their experiences accurately (see Hodgetts & Wright, 2007). Indeed, a large body of research demonstrates that memory recall is subject to distortion by various cognitive and emotional processes, such as individual perceptions and beliefs, social influences and world knowledge, which can result in errors during recall or reconstruction (Vicente & Brewer, 1993).

Notwithstanding this, there are strong arguments as to why clients' perspectives can make a valuable contribution to psychotherapy research and practice. Given that clients are active participants in therapy, it is suggested that their perspectives are vital to understanding therapy outcome (Norcross, 2002). Specifically it is argued that clients have "privileged" access to their private experiences (Elliott & Shapiro, 1992), and research suggests that change is mediated by clients' perceptions. For instance, in a review of the psychotherapy literature, Orlinsky, Ronnestad & Willutzki (2004) suggested that the therapeutic alliance, particularly as viewed by the client, is a key determinant of therapy outcome. In addition, some researchers suggests that client and therapist perceptions of what is salient in therapy differ: clients tend to value the "non-specifics" of therapy, such as the therapy relationship, whereas therapists tend to value technique (Llewelyn, 1988), stressing the importance of investigating client views in particular.

A handful of qualitative therapy process studies that explore the client's perspective have made useful contributions to our understanding of the possible ingredients of change. Clients' descriptions of what is helpful have shown that the non-technical factors of therapy are more strongly endorsed than technical factors (Bohart & Tallman, 1999). In support of this, retrospective studies have shown that clients found the therapeutic relationship more helpful than the techniques learned (Llewelyn & Hume, 1979; Murphy, Cramer, & Lillie, 1984).

In contrast, in a study by Carey et al. (2007) clients described the tools and strategies introduced in the therapy helped them gain control over their situation and were significant in bringing about change. In Messari and Hallam's (2003) discourse analysis of clients' experiences of CBT for psychosis, the majority of clients valued both the "educational component" of therapy as well as the therapy relationship,

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which was found to be "an integral part of the context of therapy" (Messari &

Hallam, 2003, p. 183), demonstrating the importance of both technique and relational

factors. Interestingly, a study by Bedi, Davis and Williams (2005) found that

techniques were cited by clients as contributing most to the development of a

therapeutic relationship, suggesting that the relationship between the technical and

relational factors is complex and requires further investigation.

There is a risk, as with all qualitative studies, of these findings being "lost as

disparate isolated islands of knowledge without some attempt to sum them up"

(Sandelowski, Docherty & Emden, 1997, p. 367). A relatively new approach,

qualitative meta- synthesis, offers a promising possibility to bring together findings

from individual studies, and build up a cumulative knowledge base that can be

usefully drawn upon in clinical practice (Pope, Mays & Popay, 2007).

There have been a number of recent attempts to synthesise qualitative studies

of CBT for particular client groups and specific CBT interventions. These meta-

syntheses include client perspectives of group CBT for post-natal depression (Scope,

Booth & Sutcliffe, 2012), service users' experiences of CBT for psychosis (Berry &

Hayward, 2011) and patients' experiences of Mindfulness-Based Cognitive Therapy

(Malpass et al., 2012). These studies have adopted a somewhat narrow focus, in that

they have restricted their inclusion criteria to clients with a specific condition,

making it difficult to make inferences about other conditions or difficulties.

The current meta-synthesis aimed to adopt a somewhat broader focus, by

including a range of client conditions, with the exception of psychosis (in light of the

recent meta-synthesis of CBT for psychosis). However, in relation to the type of

CBT approach and treatment modality, third-wave CBT approaches were excluded,

both in light of the recent Mindfulness-Based Cognitive Therapy meta-synthesis, and

because "third-wave CBT" encompasses disparate approaches, characterised by diverse theoretical underpinnings and heterogeneous techniques (Kahl, Winter & Schweiger, 2012). These are arguably as dissimilar to each other as they are to a traditional CBT approach, which may make it difficult to bring together the findings in a meaningful way.

In relation to treatment modality, it is argued that group and individual therapy can involve very different therapeutic processes, i.e. the group process in itself is argued to be an important vehicle of change (Bieling, McCabe & Antony, 2006), suggesting that it may be more useful to consider these separately. Therefore, studies examining group therapy will be excluded.

In light of the above considerations, the current meta-synthesis aimed to review qualitative studies that focus on clients' experiences of individual CBT approaches (including cognitive therapy) for mental health difficulties.

The specific questions addressed were:

1) How do clients experience the therapeutic processes of CBT? Specifically, how do they perceive technique and relationship factors?

2) What do clients experience as helpful or unhelpful in the way that CBT techniques are delivered?

Method

The search strategy was designed to identify qualitative papers that focused on clients' experiences of individual CBT. This section provides details of the inclusion criteria, search strategy and search results, followed by details of the methods used to appraise the quality of studies and to synthesise the literature.

Inclusion criteria

The inclusion criteria fell into four categories: participants, type of intervention, methodology and publication type.

Participants

- Clients in therapy for mental health difficulties with the exclusion of psychosis, and without cognitive/ neurological impairment or intellectual disability. Studies of physical health problems were excluded.

- Clients over the age of 16 including older adults. No upper age limits.

Type of intervention

- Studies involving predominately cognitive or cognitive-behavioural therapeutic approaches. Third- wave approaches (Acceptance and Commitment Therapy/ Mindfulness based Cognitive Therapy) and hybrid approaches where CBT was used in combination with other treatment approaches such as Dialectical Behaviour Therapy or Cognitive Analytic Therapy were excluded because of the difficulty in separating CBT from the other treatment approach.

- Studies examining individual, face-to-face therapeutic approaches. Studies of other modes of delivery such as group or telephone assisted were excluded

- Interventions consisting of four or more sessions, thereby excluding guided-self help or other low-contact, predominantly self- help interventions based on CBT.

Methodology

- Qualitative studies that focus on clients' in-session experience of CBT, with the exclusion of single-case design studies.

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- Studies that demonstrate systematic qualitative analysis of the data, as opposed to a mere description of the findings.

Publication type

- Peer-reviewed, English language journal articles.

Identification of studies

Studies were identified through electronic database searches, citation searches and the examination of reference lists of relevant papers. An initial scoping search of the *PsycINFO* database was conducted in order to identify studies relevant to this topic area, and to refine search terms. A systematic search of *PsycINFO* was undertaken in November 2013 in several stages, in which search terms and combinations of terms were increasingly refined. In the second stage of the search, the search terms used were:

Client*/ service user*/patient*/ participant*

AND

Experience*/ perspective*/ feedback/ view*/ perception*/ reaction*

AND

Psychotherapy/ CBT/ cognitive behavio?r*/ cognitive

AND

Qualitative/ Mixed?method

These terms were combined using the Boleean operators "and" and "or", and truncation and wildcards were used to allow for variations in American and English spelling. A search of *PsycINFO* using these terms produced 2761 results.

A search of the Medline database using the same terms yielded no additional studies, hence it was concluded that the previous searches had sufficiently captured

all relevant articles and no further searches were run. In addition to the electronic searches, hand searches of two key journals, *Behavioural and Cognitive Psychotherapy* and *Psychotherapy Research,* were conducted for the years 2001-2010. Citation searches of papers identified from the database searches were also conducted.

Study selection

Figure 1 shows the process of study selection. A total of 2761 studies were initially scanned by title for relevance, and 741 studies were identified as being sufficiently relevant to have their abstracts examined against the inclusion criteria. Of the 2020 studies excluded, the majority were rejected because they did not examine clients' experiences of a psychological intervention.

Of the remaining 741 studies, a further 698 studies were excluded on review of abstracts for the following reasons: the majority were not qualitative, a substantial number studied clients with psychosis or physical health problems, some studies examined hybrid or third wave CBT approaches, and some examined group approaches. In addition, several studies were rejected for examining computer and telephone assisted therapy.

A total of 43 full texts were selected for an in-depth appraisal against the inclusion criteria. Of these, 37 were excluded (see section below on excluded studies) and six were included in the final review. With the addition of two studies identified through hand searches, and one identified through citation searches, a total of nine studies were included in the final review.

Figure 1

The process of study selection
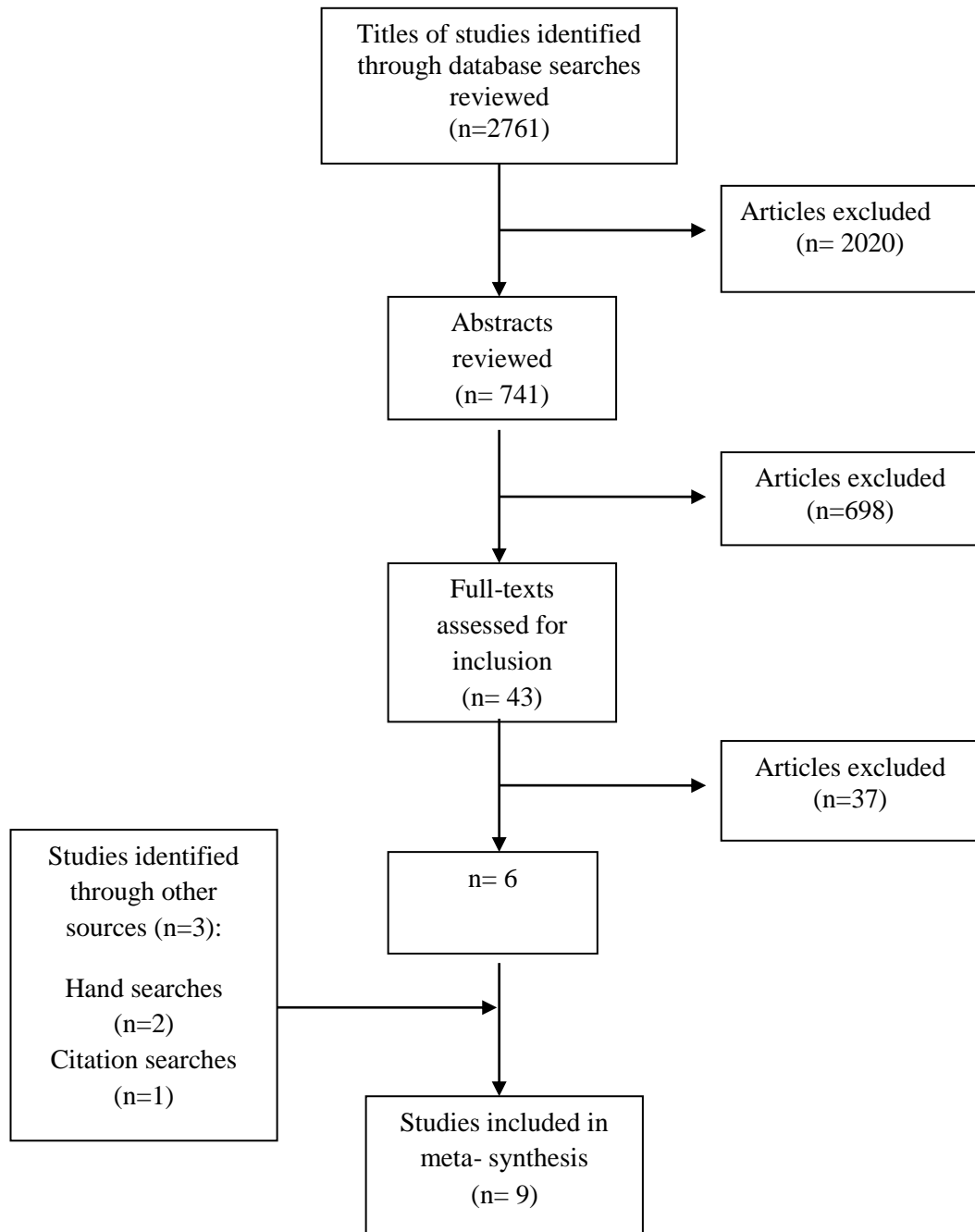
Excluded studies

Of the 37 studies excluded, the majority were rejected because the qualitative analysis in some studies was primarily descriptive as opposed to analytic (typically in studies that were add-ons to quantitative studies), some studies had a focus that was vastly different to the focus of this review question, and some initially appeared to meet the criteria of investigating a cognitive therapy intervention, for example "cognitive bias modification" or an "integrated CBT/ exercise programme", but on closer examination, did not have enough of a cognitive therapy component to meet the inclusion criteria.

Several studies were initially considered for inclusion, but on reflection fell outside the specified criteria. One study (Shearing, Lee & Clohessy, 2011) was a qualitative analysis of clients' experiences of an isolated behavioural technique (trauma re-living) delivered as part of a complete CBT intervention.

This study was excluded on the basis that it did not capture clients' experiences of the cognitive elements of intervention, and therefore provided an inaccurate picture of clients' experiences of a cognitive behavioural intervention. In comparison, a study of clients' experiences of a complete trauma-focused CBT intervention was included in the review (Vincent, Jenkins, Larkin & Clohessy, 2012). Additionally, one study was excluded because it focused solely on clients' experiences of positive and negative change following therapy, as opposed to clients' experiences of the intervention (Gostas, Wiberg, Neander & Kjellin, 2012).

Data extraction

A data extraction form was used to summarise the characteristics of studies to be included in the review. This form summarised details of the author, date of study, client population and demographics, client presenting problem, type and duration of

therapeutic intervention and method of data collection and analysis. This provided a way to extract findings from each study in a consistent manner, thereby reducing judgment bias.

Appraisal of studies

It is generally accepted that quality appraisal of studies is essential in qualitative research; however, there is considerable debate about the methods of quality assessment, for instance, whether it is possible to come up with a set of "gold standard" criteria for a field of research which encompasses a plurality of methodologies, and whether criteria should be utilised as a set of guidelines or "rigid requirements" (Dixon-Woods, Shaw, Agarwal & Smith, 2004). This discussion is part of a wider debate about different epistemological positions underlying quantitative and qualitative research (and to some extent within the field of qualitative research) regarding what is of interest, and therefore what constitutes "quality" (Dixon-Woods et al., 2004).

Some researchers have called for an end to ''criteriology'' (Schwandt, 1996), claiming that it stifles the interpretive and creative process of qualitative research. Others, however, have argued that quality criteria need not be utilised prescriptively, and can be helpful guides to good practice, provided that the particular goals of qualitative research are held in mind (Mays & Pope, 2000; Spencer, Ritchie & O'Conner, 2003).

In view of the lack of a unified approach, guidance was sought from the Cochrane Qualitative Research Methods Group (CQRMG; Hannes, 2011) to decide upon the most appropriate method of quality appraisal for this review. The Cochrane group emphasises the importance of taking into account the core elements of qualitative research: credibility, transferability, dependability and confirmability (see

Table 1 below), in the appraisal of qualitative studies, regardless of the method of appraisal chosen (Hannes, 2011). They suggest the use of an appraisal tool, in assisting the appraisal process, but do not prescribe a "gold standard" methodology for how this should be used, i.e. to exclude studies or simply describe quality, appreciating the value in all of these approaches (Hannes, 2011).

Based on CQRMG recommendations (Hannes, 2011), the appraisal process in this study was guided by the Critical Appraisal Skills Programme's (CASP) 10 questions for qualitative research (CASP, 2002), taking into account the four core-criteria of qualitative research outlined above. The CASP was used as a set of guidelines that draw attention to features relevant to quality, as opposed to a checklist (see Table 2).

Method of analysis

Despite an increasing recognition of the value of meta-synthesis, there is currently no agreed guidance on how to conduct one. A variety of different approaches to meta-synthesis are described in the literature; broadly speaking these fall on a spectrum from aggregative/summative approaches, such as thematic analysis or meta-aggregation, to interpretive and theory generating approaches such as meta-ethnography, depending on the type of review question (Noyes & Lewin, 2011).

Guidance from the CQRGM (Hannes, 2011) states that reviews focusing on summarising or aggregating data into themes are best suited to meta-aggregation or thematic analysis; hence, the study findings in this review were synthesized using thematic analysis without theory generation. Braun and Clarke's (2006) paper on thematic analysis, and published worked examples (e.g. Carlson, Glenton & Pope, 2007) were consulted as methodological guides for the current synthesis.

Table 1

Core criteria for quality assessment. Taken from Cochrane Qualitative Research Methods Group guidance (CQRMG; Hannes, 2011)

Quality criterion and definition	Evaluation techniques
Credibility evaluates whether or not the representation of data fits the views of the participants studied, whether the findings hold true.	Member checks, peer debriefing, attention to negative cases, independent analysis of data, verbatim quotes, persistent observation etc.
Transferability evaluates whether research findings are transferable to other specific settings.	Providing details of the study participants , providing contextual background information, demographics, the provision of thick description about both the sending and the receiving context etc.
Dependability evaluates whether the process of research is logical, traceable and clearly documented, particularly on the methods chosen and the decisions made by the researchers.	Peer review, debriefing, audit trails, triangulation, reflexivity and calculation of inter-rater agreements etc.
Confirmability evaluates the extent to which findings are qualitatively confirmable through the analysis being grounded in the data and through examination of the audit trail.	Assessing the effects of the researcher during the research process, reflexivity, providing information on the researcher's background, education, perspective, school of thought etc.

Table 2

Guidelines for critical appraisal used in the current review: an amended version of the Critical Appraisal Skills Programme (2002) questionnaire.

Question	Considerations
1. Was there a clear statement of the aims of the research?	• The researcher makes clear the goal of the research, and its importance and relevance.
2. Is a qualitative methodology appropriate?	• The research seeks to illuminate the actions and/or subjective experiences of participants
3. Was the research design appropriate to address research aims?	• The researcher has justified the research design (e.g. discussed how they decided which methods to use?)
4. Was the recruitment strategy appropriate to the research aims?	• The researcher has explained how and why the participants were selected • The researcher has discussed recruitment issues (e.g. why some people chose not to take part, bias in the sample).
5. Were the data collected in a way that	• The setting for data collection is justified.

addressed the research issue?	• The approach to data collection is clear (e.g. focus group, interview etc.) and justified • Data collection methods are detailed and explicit • Form of data is clear e.g. tape recordings, video material, notes etc • Saturation of data has been discussed.
6. Has the researcher- participant relationship been adequately considered?	• The researchers have critically examined their own role, preconceptions, potential biases and influences during the research process.
7. Have ethical issues been taken into consideration?	• There are sufficient details of how the research was explained to participants, to assess whether ethical standards were maintained. • The researcher has discussed issues of informed consent, confidentiality or effects of the study on participants.
8. Was the data analysis sufficiently rigorous?	• There is an in-depth description of the analysis process, e.g. how categories/themes were derived from the data. • Sufficient data are presented to support the findings.

	• The researcher explains how the data were selected from the original sample
	• Contradictory data are taken into account.
9. Is there a clear statement of findings?	• The findings are explicit
	• There is adequate discussion of the evidence both for and against the researcher's arguments
	• The researcher has discussed the credibility of findings (e.g. triangulation, respondent validation, more than one analyst.)
	• The findings are discussed in relation to the original research questions
10. How valuable is the research?	• The researchers have discussed the contribution the study makes to existing knowledge (current practice, policy, or relevant research literature).
	• They identify new areas where research is necessary
	• The researchers have discussed whether/how findings can be transferred to other populations

Thematic analysis

Initial considerations. Prior to conducting the thematic analysis, a major consideration that had to be made was deciding what constitutes data, given that in a meta-synthesis, the primary data (i.e. interview transcripts from primary studies) is not typically accessed (Patterson, Thorne, Canam & Jillings, 2001). In the absence of guidance in relation to this, it was decided that all of the text that appeared under the findings/ results heading in the primary studies (Thomas & Harden, 2007), i.e., the themes and categories, their descriptions, and examples, constituted data in this meta-synthesis.

A related point is that the process of analysis cut across theme labels; it aimed to focus on the ideas presented, regardless of how they were labelled and organised in the primary studies. However, the categories or themes from which the ideas were extracted from were carefully documented to provide transparency and demonstrate that the findings were "grounded in data" (Hannes, 2011), as opposed to being the result of the prior understandings and preferences of the researcher.

Steps of analysis. The thematic analysis of the studies' findings was conducted as it would be in primary qualitative research (Braun & Clarke, 2006). Stage 1 involved becoming familiar with the data; this involved reading and re-reading the findings in each study and noting down some initial codes. Stage 2 involved line by line coding of the findings, resulting in the generation of a list of initial codes for each paper. At this point the researcher began to identify repeated patterns within and across studies. Stage 3 involved reviewing the code lists for each study, combining, clustering, labelling and classifying the results into a hierarchical structure of domains and themes. These were then compared and integrated across

the studies, and refined and reviewed to ensure that they provided an accurate as possible representation of the data.

In order to ensure the validity of findings, two experienced qualitative researchers provided supervision throughout, and in-depth discussions at stage 3 concerning labelling and classification of themes and domains led to some minor changes. Throughout the process of data analysis, attention was given to the quality appraisal of each of the studies, ensuring that this was accounted for in the data. Less weight was given to the weaker studies during analysis, for example, themes (or descriptions of participants' experiences) that came up in a methodologically weaker study were treated more cautiously than if it had come from a stronger study.

Results

This section presents the findings from the nine studies included in the review, beginning with a summary of the studies' characteristics, followed by a methodological appraisal of the studies, and ending with the meta-synthesis.

Description of included studies

Details of the study aims, sample, method of data collection and analysis and nature of CBT intervention for the nine studies are summarised in Table 3.

Study aims

Although all of the studies sampled clients' experiences of CBT, several studies had a different emphasis or additional focus that was broader than question of this review. For example, the study by McManus, Peerbhoy, Larkin and Clarke (2010) aimed not only to explore clients' experiences of CBT for social phobia, but there was a theme devoted to the impact of social phobia on clients' lives prior to receiving therapy, and the process of help-seeking.

Table 3

Study characteristics

Study	Aims	Sample	Setting	Intervention	Data collection method(s)	Analysis
Ayers et al. (2012)	Explore therapist and patient perspectives of a CBT intervention, to provide insight into factors affecting treatment outcome.	12 (7 women) older adults with hoarding difficulties, aged 66-87	Community healthcare service	26 sessions of manualised CBT for hoarding	Focus group	Collective case study
Barnes et al. (2013)	Investigate what participants found challenging about CBT and how this impacted on their treatment experience	26 adults (16 women) with depression, mean age 47	Primary care service	12-18 sessions of CBT for depression	Semi-structured interviews	Framework analysis
Berg et al. (2008)	Elicit patient feedback about the utility, strengths, barriers, and limitations of CBT-AD for HIV patients.	14 adults (1 woman) with HIV and depression, aged 31-53	Not specified	10 sessions of CBT-AD (treatment for medical adherence and depression)	Semi-structured interviews	Not specified, description resembles thematic analysis
Clarke et al. (2004)	Describe clients' experiences of CT and their explanations for how change came about.	5 adults (4 women) with depression, aged 24-56	Joint NHS and research clinic	12-20 sessions of CBT for depression	Semi-structured interviews	Grounded theory
Gega et al. (2013)	Compare individual experiences and therapeutic	6 adults (2 women) with depression	Primary care service	6 sessions of CBT	Semi-structured interviews	Thematic analysis

	processes in cCBT (computerised) and tCBT (therapist –delivered).	and anxiety, aged 19-33				
Gostas et al. (2013)	Understand clients' experiences of psychotherapy contracts and processes in CBT and PDT.	6 adults (4 women) with a range of psychiatric diagnosis aged 28-48	Privately funded Psychotherapy centre.	10-146 (median: 21) sessions of CBT	Semi-structured interviews	Content analysis
McManus et al. (2010)	Understand patients' experiences during CBT, and impact of different aspects of the treatment	8 adults (5 women) with social phobia aged 23-38.	Specialist service for Anxiety Disorders and Trauma	10-18 (mean: 13) sessions of cognitive therapy for social phobia	Semi-structured interviews	Interpretative phenomenol-ogical analysis
Nilsson et al. (2007)	Compare patients' experiences of psychodynamic therapy and CBT; changes that have occurred, how these changes have come about, and unhelpful aspects.	31 adults (27 women) with a range of psychiatric problems receiving treatment, aged 20-65(separate demographics for CBT and PDT not given)	Private outpatient clinic	2- 48 months (median: 24 sessions) of CBT	Semi-structured interviews	Patients clustered into ideal types
Vincent et al. (2012)	Consider the acceptability of trauma focused CBT (TFCBT) for asylum-seekers with PTSD by exploringclients' experiences.	7 asylum seekers (3 women) with PTSD, aged 19-42	Specialist trauma clinics and primary care services	7-20 (median: 8) sessions of CBT based psycho-education and trauma focused CBT	Semi-structured interviews	Interpretative phenomenolo gical analysis

In addition, Barnes et al. (2013) explored clients' views of CBT, but focused primarily on the challenges of CBT and aspects that clients were dissatisfied with; a focus narrower than the aims of this review.

One study investigated therapist as well as client perspectives (Ayers, Bratiotis, Saxena & Wetherell, 2012), and there were three comparative studies (Gega, Smith & Reynolds, 2013; Gostas, Wiberg, Neander & Kjellin 2013; Nilsson, Svensson, Sandell & Clinton, 2007). The study by Gega et al. (2013) explored clients' perspectives of both therapist-delivered CBT (tCBT) and computerised CBT (cCBT) (Gega et al., 2013).

Nilsson et al. (2007) explored differences in clients' experiences of change in CBT and PDT, and clients were questioned on their experiences of being in therapy, the changes achieved, as well as their beliefs about how change came about. However in these studies, the analysis and presentation of findings meant that the findings specific to client experiences of CBT were easily extractable for the purposes of this review.

Sample

The majority of studies were conducted in the UK. Two were conducted in the USA and one in Sweden. Sample size ranged from five to 26 (mean= 11). All but one study sampled adults of working age (Ayers et al., 2012 sampled older adults), and the majority of studies sampled clients with depression and/or an anxiety disorder (identified in 7/9 studies). In the remaining two studies, information about diagnosis was not provided. In the Nilsson et al. (2007) study, the authors stated that no formal psychiatric diagnosis was available to them, and client's difficulties "covered a spectrum of both neurotic and psychotic problems". In the study by

Gostas et al. (2013), participants were described as "persons with a psychiatric diagnosis"; however no further information was provided.

Nature of CBT intervention

In all studies, the CBT intervention that clients received was delivered individually and face-to-face. The majority of studies reported that the CBT intervention was relatively brief, ranging from an average of 6 to 26 sessions (mean= 14).

In five of the studies, the CBT intervention comprised a manualised CBT treatment protocol adapted for a particular psychological concern, such as hoarding (Ayers et al., 2012) or social phobia (McManus et al., 2010). Of these, one intervention was an adaptation for patients with depression and HIV (Berg et al., 2008). In the remaining four studies clients received a generic CBT intervention (Barnes et al., 2013; Clarke, Rees & Hardy, 2004; Gega et al., 2013; Nilsson et al., 2007).

Data collection and analysis

All but one study (Ayers et al., 2012) used semi-structured individual interviews as their method of data collection. Ayers et al. (2012) collected data from multiple sources: observation, participants' feedback ratings, in-session notes, and a focus group, consistent with the aims and methodology of the study (collective case study). For the purposes of this review, only the focus group data was subject to analysis.

Broadly speaking, the majority of studies fell within a phenomenological research tradition: two studies used a type of thematic analysis, two used interpretive phenomenological analysis (IPA), and one used content analysis. One study took a grounded theory approach and the remaining three used less well-known types of

qualitative analysis methodology. In all, the analytic procedures were well described and referenced adequately.

Methodological appraisal of studies

The Critical Appraisal Skills Programme's (CASP) 10 questions for qualitative research (Critical Appraisal Skills Programme 2002) and the core areas of credibility, transferability, dependability and confirmability guided the appraisal of studies in this review. This section provides a discussion of the quality of studies and their ability to answer this review's question, in relation to the four core areas (outlined in the methods section). Table 4 below summarises the main limitations of the nine studies included in the review.

Credibility

Credibility is concerned with whether the representation of data, fits the views of the participants studied (Hannes, 2011). There are a number of techniques to evaluate credibility (see method). Generally speaking, the majority of studies described processes that were undertaken to check the credibility of findings (the extent to which a study's representation of the data fits the views expressed by participants; Hannes, 2011). Firstly, in all studies, the theme descriptions were supported by verbatim quotations from participants, enabling the reader to judge the fit of authors' interpretations.

In addition, the majority of studies gave attention to negative or contradictory cases, and explored these in some detail, enhancing confidence that the views of a range of participants were adequately represented (Mays & Pope, 2000). The exceptions to this were papers by Ayers et al. (2012) and Gega et al. (2013), which did not given sufficient consideration to the instances/ cases that did not fit with the described pattern.

Table 4.

Study Limitations

Study	Main limitations
Ayers et al. (2012)	- Negative or contradictory findings/cases poorly represented. - Lack of clarity regarding which data was drawn on for particular viewpoints expressed by participants. - Absence of information about the nature and format of data collection methods. - Absence of discussion about the influence of prior understandings on the research process.
Barnes et al. (2013)	- Absence of discussion about the influence of prior understandings on the research process. - Some accounts failed to capture participants' quotations presented in appendices of paper.
Berg et al. (2008)	Absence of discussion about the influence of prior understandings on the research process.
Clarke et al. (2004)	- On some occasions theme labels appeared not to adequately capture descriptions. - Absence of discussion about the influence of prior understandings on the research process.
Gega et al. (2013)	- Negative or contradictory findings/cases poorly represented - Absence of discussion about the influence of prior understandings on the research process.
Gostas et al. (2013)	Lack of clear evidence of specific procedures to ensure credibility, i.e. credibility checks
McManus et al. (2010)	- Insufficient description of the analysis process - Absence of discussion about the influence of prior understandings on the research process.

Nilsson et al. (2007)	• Absence of discussion about the influence of prior understandings on the research process.
	• Omission of individual demographics for clients' undertaking CBT and PDT limiting transferability of findings.
Vincent et al. (2012)	• Absence of discussion about the influence of prior understandings on the research process.

All but one study (Gostas et al., 2013) provided clear evidence of specific procedures or credibility checks undertaken, to ensure the trustworthiness of findings. These involved independent analysis of the data by more than one researcher (Barnes et al., 2013; Berg, Raminani, Greer, Harwood & Safren, 2008; Clarke et al., 2004; Gega et al., 2013; Nilsson et al., 2007), the review of an audit trail of the research process (Vincent et al., 2012) and peer debriefing/ supervision (Ayers et al., 2012; McManus et al., 2010). Gostas et al. (2013) stated that interviews were read several times by two authors, but did not specify whether this or any other part of the analysis was carried out independently.

Finally, the credibility of findings in the study by Ayers et al. (2012) was enhanced by the use of different methods: triangulation, observation, focus groups, in session notes and homework assignments, which enhances credibility, through "ensuring comprehensiveness and encouraging a more reflexive analysis of the data" (Mays & Pope, 2000, p. 51). However, at times it was not made clear which data was drawn on for particular viewpoints expressed by participants.

Transferability

This criterion evaluates whether research findings are transferable to other settings and populations (Hannes, 2011). All of the studies contextualised the sample, providing details of participant demographics including age and gender, and some described additional details including ethnicity, marital status and occupation. All studies with the exception of two (Gostas et al., 2013; Nilsson et al., 2007), detailed the nature of participants' psychological difficulties, and the majority of studies described the assessment tools/ diagnostic guidelines used to ascertain this. A weakness of the Nilsson et al. (2007) study is that it failed to provide individual demographics for clients undertaking CBT and PDT.

The majority of studies provided detailed descriptions of the intervention received (nature, length and frequency of sessions), and many denoted whether participants were "completers" and "non-completers". In addition, all but one study (Berg et al., 2008) provided information about the study setting and the nature of the healthcare system within which the study took place, including whether it was privately or publicly funded, giving the reader a rich description of the "sending context" (Hannes, 2011). Furthermore, the majority of papers denoted the demographic characteristics of participants quoted in the results section, enabling the researcher to consider whether different views were expressed by those with different demographic characteristics.

Dependability

Dependability evaluates whether the process of research is logical, traceable and clearly documented, particularly on the methods chosen and the decisions made by the researchers (Hannes, 2011). On the whole, all of the papers clearly documented the study aims, data collection and data analysis methods. Qualitative methodology was considered an appropriate choice for all studies, given their exploratory nature and focus on participants' subjective experiences. The majority of studies, however, did not specify the research tradition guiding their research, with the exception of two studies using IPA (McManus et al., 2010; Vincent et al., 2012), and one using grounded theory (Clarke et al., 2004). Providing the reader with this information increases transparency in the research process, and enables the reader to make more informed judgments about the appropriateness of design, data collection and analysis.

A clear account of the process of data collection and analysis was present in the majority of studies; they clearly documented how interviews were conducted, and

the content of the interview schedules, with the majority providing sufficient details for easy access to the interview schedule. Ayers et al. (2011), however, the only study to use a focus group, provided no information about the nature and format of this.

In relation to data analysis, studies varied in the quality of their descriptions. Clarke et al. (2004) and Nilsson et al. (2007) very clearly documented the stages of the analytic process and articulated the decision trail in detail, describing how initial simple coding evolved into more sophisticated structures, categories and themes. McManus et al. (2010), however, provided very little detail of their process of analysis, instead directing the reader to standard analytic procedures in the literature.

Moreover, in some papers, the way in which authors' had grouped and labelled some of participants' descriptions and themes did not always make intuitive sense. For instance, in the study by Clarke et al. (2004), the category "resistance and fear", which reflected on clients resistance and hesitations at the beginning of therapy, did not appear to reflect the overarching cluster (or theme) label "the listening therapist". In addition, in the study by Barnes et al. (2013) some of the summaries of participants' accounts in the findings section did not appear to fully capture participants' verbatim quotations (which were presented in the appendix section). For example, quotes corresponding to the theme "no pain, no gain" containing positive feedback about the therapist did not appear to be represented in the findings section.

In addition, although descriptions of the research process were fairly well documented, the rationale for decisions made, such as why the setting and participants were considered most appropriate for the research aims, and why the

method of data collection was chosen, were less well documented, calling into question the dependability of the findings.

Confirmability

The majority of studies described procedures undertaken to ensure that the findings were "grounded in the data" (Hannes, 2011), and not the result of the pre-understandings and preferences of the researcher. The majority demonstrated an awareness of the potential for the researchers' assumptions and knowledge to influence the research process, and reflected on attempts made to "bracket" these, to "allow patients' experiences to speak for themselves" (Nilsson et al., 2007). Four of the studies described the use of self-reflection diaries or consultation to enhance transparency and self-reflexivity in the analytic process (Ayers et al., 2012; Clarke et al., 2004; Gega et al., 2013; Vincent et al., 2012). A shortcoming of the remaining studies is that they did not discuss the need to minimise bias in the research process (Berg et al., 2008; Gostas et al., 2013).

Several papers provided the names of the authors who collected the data (Clarke et al., 2004; Gega et al., 2013; Nilsson et al., 2007; Vincent et al., 2012) and those who analysed the data (Barnes et al., 2013; Clarke et al., 2004; Gostas et al., 2013; McManus et al., 2010; Nilsson et al., 2007; Vincent et al., 2012). However, with the exception of Clarke et al. (2004) and Nilsson et al. (2007), details about the profession and background of interviewers and analysts were not provided. Furthermore, in all but one study (Gostas et al., 2013; and even this was extremely brief), the authors did not discuss how their prior understandings might have influenced the research process. This is certainly a limitation of the studies, because it makes it difficult for the reader to determine the extent to which the data can be accepted as grounded in clients' experiences and viewpoints.

Meta-synthesis

The meta-synthesis generated ten themes clustered into three domains: "Technical aspects of CBT", which refers to the techniques applied in therapy; "The therapeutic relationship", referring to the bond between therapist and client; and "The therapeutic journey: from doubt to belief", describing changes in clients' attitudes, and engagement with the therapy. The evidence for these themes came primarily from studies that had been identified as methodologically strong. Table 5 shows the themes and categories from primary studies that had aspects relevant to each of the meta-analytic themes.

Many of the meta-analytic domains and themes developed in the current study do not appear to reflect the categories and themes from the primary studies, and the domain/theme labels bear little resemblance to each other. This is because relevant content in primary studies was dispersed across several themes, and as stated in the methods section, the analysis focused on the main ideas presented, regardless of how they were labelled and organised in the primary studies.

Technical aspects of CBT

This domain describes clients' experiences of the technical aspects of the therapy: procedures or tasks that were introduced by the therapist, with the aim of influencing thoughts, feelings or behaviour. The four themes in this domain outline the techniques most commonly reported across the studies, and are presented in chronological order, i.e. as they typically occur in the therapy. The frequency and salience of particular client experiences is indicated within each category.

Table 5.

Meta-analytic categories of participants' experiences of CBT and corresponding categories from primary studies

Meta-analytic domains and themes	Categories in primary studies
1. Technical aspects of CBT	
1.1 A new explanation of symptoms	Evidence (7 studies): *Barnes et al. 2013*; CBT sessions (If I),CBT homework *Berg et al. 2008*; General experience, adherence training and overview of CBT *Clarke et al. 2004*; Excited and absorbed, the model, understanding/ patterns/ core beliefs *Gega et al. 2013*; Awareness building, making links, alleviation of self-blame or shame *McManus et al. 2010*; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy *Nilsson et al. 2007;*The satisfied CBT patient, common experiences among dissatisfied patients *Vincent et al. 2012;* Staying where you are versus engaging in therapy, experiences encouraging engagement in therapy, importance of therapeutic relationship.
1.2 Learning to think differently	Evidence (6 studies): *Ayers et al. 2012*; Unhelpful aspects of treatment *Barnes et al. 2013*; CBT homework; no pain no gain *Berg et al. 2008*; Cognitive restructuring *Clarke et al. 2004*; Dealing with thoughts *Gega et al. 2013;* Examining and dealing with thoughts *McManus et al. 2010*; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy
1.3 Doing things differently	Evidence (8 studies): *Ayers et al. 2012*; Helpful aspects of treatment *Barnes et al. 2013*; CBT homework *Berg et al. 2008*; Behavioural activation *Gega et al. 2013*; The tool kit: learning by doing *Gostas et al. 2013*; Psychotherapy aimed at self-help *McManus et al. 2010*; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy *Nilsson et al. 2007*; The satisfied CBT patient *Vincent et al. 2012*; Staying where you are versus engaging in therapy

1.4 Applying tools to the "real world"	Evidence (7 studies):
	Ayers et al. 2012; Helpful aspects of treatment
	Barnes et al. 2013; CBT homework, no pain no gain
	Berg et al. 2008; General experience, behavioural activation
	Clarke et al. 2004; Testing things out
	Gostas et al. 2012; Psychotherapy was "hard work"
	McManus et al. 2010; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy, challenges faced in the pursuit of change
	Nilsson et al. 2007; The satisfied CBT patient

2. The therapeutic relationship

2.1 A positive relational bond	Evidence (9 studies):
	Ayers et al. 2012; Helpful aspects of treatment
	Barnes et al. 2013; CBT sessions (if I)
	Berg et al. 2008; Participants' reactions to the patient-therapist relationship
	Clarke et al. 2004; Excited and absorbed
	Gega et al. 2013; Human element
	Gostas et al. 2013; The psychotherapist's skill and personal traits inspired confidence
	McManus et al. 2010; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy
	Nilsson et al. 2007; Common experiences among the satisfied patients,the satisfied CBT therapist
	Vincent et al. 2012; Importance of therapeutic relationship

2.2 A safe trusting environment	Evidence (8 studies):
	Barnes et al. 2013; CBT sessions (if I;)
	Berg et al. 2008; Participants' reactions to the patient-therapist relationship
	Clarke et al. 2004; Excited and absorbed
	Gega et al. 2013; Human element
	Gostas et al. 2013; The psychotherapist's skill and personal traits inspired confidence
	McManus et al. 2010; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy
	Nilsson et al. 2007; The dissatisfied CBT patient
	Vincent et al. 2012; Importance of therapeutic relationship

2.3 Collaboration	Evidence (6 studies)
	Barnes et al. 2013; CBT (if I)
	Clarke et al. 2004; Excited and absorbed
	Gostas et al. 2013; Cooperation with the therapist was created continuously
	McManus et al. 2010; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy
	Nilsson et al. 2007; Common experiences among the satisfied patients
	Vincent et al. 2012; Experiences encouraging engagement in therapy

3   The therapeutic journey: from doubt to belief

3.1 Initial ambivalence about engagement	Evidence (7 studies) *Ayers et al. 2012*; Helpful aspects of treatment *Barnes et al. 2013*; CBT sessions (If I) *Berg et al. 2008*; General experience *Clarke et al. 2004;*Resistance and fear; excited and absorbed *Gostas et al. 2013*; Psychotherapy was hard work *McManus et al. 2010*; Challenges faced in the pursuit of change *Vincent et al. 2012*; Staying where you are versus engaging in therapy, experiences impeding engagement in therapy, experiences encouraging engagement in therapy
3.2 Recognition of self as agent of change	Evidence (6 studies) *Berg et al. 2008*; Behavioural activation, problem solving *Clarke et al. 2004*; Resistance and fear, testing things out *Gega et al. 2013;* Insight *Gostas et al. 2013*; Psychotherapy aimed at self-help *McManus et al. 2010*; Challenges faced in the pursuit of change *Nilsson et al. 2007*; The satisfied CBT patient
3.3 Benefits and realisations	Evidence (7 studies) *Barnes et al. 2013*; No pain no gain *Berg et al. 2008*; General experience *Clarke et al. 2004;* Feeling more comfortable with self *Gega et al. 2013*; New self vs. old self, insight *McManus et al. 2010*; A whole new world, new ways of being *Nilsson et al. 2007*; The satisfied CBT patient, the dissatisfied CBT patient *Vincent et al. 2012*; Regaining life, losing oneself

A new explanation of symptoms

An ingredient of therapy discussed in seven of the studies was the process of developing an alternative explanation for clients' symptoms. This occurred through the process of developing a formulation, the provision of a diagnosis and the therapist sharing information about others with similar difficulties. In the majority of studies (6/9), clients felt these processes to be paramount in enabling them to revise their views about their difficulties and themselves, and increasing hope that things can be different.

Regardless of the specific CBT formulation (a cross-sectional thoughts, feelings and behaviour model, or an in depth case conceptualisation mapping the role of early experiences), the practice of developing a formulation with the therapist was identified in four studies as crucial in helping clients to feel less ashamed about their difficulties, and less "crazy" (Nilsson et al., 2007) or abnormal for experiencing symptoms. However, the major function of formulation as described by clients in six studies was its role in increasing insight into clients' difficulties and opening up possibilities for change; clients reported a greater awareness of the interactions between their thoughts, feelings, behaviour, and the way in which these maintain the problem. Clients who learned about longer term processes (core beliefs), and their role in the development of their problems, described having a deeper understanding of longstanding patterns in their lives and better self-awareness in general (Clarke et al., 2004).

However, in two studies, a minority of clients alluded to feeling dissatisfied with the formulation developed with their therapist, feeling that it lacked depth (i.e. historical factors were not considered) and that it did not get to the "root cause" of their difficulties (Barnes et al., 2013; Nilson et al., 2007). In addition, for some

participants the CBT model was experienced as too simplistic and rigid for their difficulties (Barnes et al., 2013).

In addition to the process of formulation, participants in three studies described receiving a diagnosis from the therapist or learning about others with similar difficulties (Vincent et al., 2012; Nilsson et al., 2007; McManus et al., 2010). This helped to normalise clients' difficulties, and provided assurance that "something can be done about it [the problem]" (Nilsson et al., 2007, p. 561).

Learning to think differently

Clients in the majority of studies (6/9) described thought challenging as an important intervention in their therapy. They explained that the cognitive tools learnt enabled them to exercise scrutiny over the thoughts that "pop into" their minds (Gega et al., 2013). This helped them to perceive situations from a more balanced, objective viewpoint, which resulted in more rational responses (Barnes et al., 2013; Berg et al., 2008; McManus et al., 2010).

Participants in some studies perceived the structured cognitive record sheets to be particularly helpful (Clarke et al., 2004; McManus et al., 2010), however this was not the case for all participants (Ayers et al., 2012; Berg et al., 2008; Barnes et al., 2013; McManus et al., 2010). Several participants across three studies described the cognitive work as too abstract and did not fully grasp how to use the tools (Ayers et al., 2012; Berg et al., 2008; McManus et al., 2010). A minority of clients in other studies found the process of writing down their thoughts time consuming (Berg et al., 2008; McManus et al., 2010). In all, it appeared that the participants who gave negative feedback about the cognitive tools reported struggling generally with the CBT approach (Barnes et al., 2013) and the consolidation of skills during therapy (McManus et al., 2010).

Doing things differently

Techniques that involved clients performing alternative behaviours in situations previously feared and/ or avoided were identified by clients in eight studies, as a central component of their therapy. The interventions cited most frequently by patients were exposure, i.e. the confrontation of difficult situations or experiences (Ayers et al., 2012; Gostas et al., 2013; Nilsson et al., 2007; Vincent et al., 2012), and behavioural activation, i.e. activity scheduling (Barnes et al., 2013; Berg et al., 2008; Gega et al., 2013; Vincent et al., 2012).

Clients in two studies felt exposure tasks to be the primary ingredient of change (Ayers et al., 2012; Vincent et al., 2012). To the surprise of clients, the initial anxiety and discomfort evoked during these tasks subsided with repeated exposures, and this gave clients a powerful sense of satisfaction and hope (Ayers et al., 2012; Berg et al., 2008; Nilsson et al., 2007; Vincent et al., 2012). Significantly, clients in three studies stated that confidence in their therapist, trust, encouragement and support were crucial in facilitating engagement with this task (Ayers et al., 2012; Nilsson et al., 2007; Vincent et al., 2012).

Clients who engaged in behavioural activation (Berg et al., 2008; Gega et al., 2013; Vincent et al., 2012) described valuing their therapists' suggestions to schedule rewarding activities, and spoke of the positive impact it had on their thinking, mood and self-esteem (Berg et al., 2008). However, a minority of clients spoke of the difficulty in following through with tasks scheduled, having been inactive and socially isolated for some time (Vincent et al., 2012), and a few participants found the process of completing the activity forms tedious (Barnes et al., 2013; Berg et al., 2008).

Applying tools to the "real world"

Participants across the majority (7/9) of studies commented on the aspects of therapy that facilitated the transfer of skills learnt in therapy to their everyday lives. For instance, clients in five studies showed that they greatly valued the formal homework tasks set by their therapist, explaining that these provided them with "active things" they could do to relieve their symptoms in between sessions (Berg et al., 2008; Clarke et al., 2004; McManus et al., 2010), which gradually became integrated into clients' habitual behaviour (Clarke et al., 2004; McManus et al., 2010; Nilsson et al., 2007).

Moreover, clients described receiving homework, and therapy being presented as a "skill-teaching process" (Clarke et al., 2004) in which clients "find their own way to self-help" (Gostas et al., 2013), encouraged them to take greater ownership of their problems and "make an effort to change" (McManus et al., 2010). This was evident through clients' descriptions of seeking opportunities themselves to practice skills outside of therapy (Clarke et al., 2004; McManus et al., 2010).

However, some participants across three studies had qualms about homework tasks set by the therapist (Berg et al., 2008; Barnes et al., 2013; McManus et al., 2010). Structured worksheets for recording thoughts, feelings and behaviours were experienced as too time consuming and effortful (Berg et al., 2008). Some clients spoke of a fear of "getting caught" by others whilst completing homework (Barnes et al., 2013), and others felt wary about completing it in the absence of emotional support from the therapist (Barnes et al., 2013). In addition, several clients reported being unsure of what they had been asked to do and were worried that they would make errors (Berg et al., 2008; Barnes et al., 2013). Finally, some clients described

the emphasis on homework tasks felt invalidating, and left little time for listening and reflection (Barnes et al., 2013; Nilsson et al., 2007).

The therapeutic relationship

This domain describes clients' experiences of the relational aspect of the therapeutic experience. In all but one study, clients cited the relationship as critical to engagement with therapy. Participants' accounts made reference to the following components of the therapist-client relationship: a positive relational bond, a safe and trusting environment, and collaboration.

A positive relational bond

Clients in four studies reflected on the value of entering into a relationship with a kind, pleasant and open person whom they liked "as a person" (McManus et al. 2010) and with whom they felt "a kind of personal chemistry" (Nilsson et al. 2007). Clients explained that this developed through the therapist demonstrating empathy: listening, understanding and providing validation (8/9 studies). In addition, clients in two studies (Gega et al., 2013; Vincent et al., 2012) reported that therapists simply relating to them as a human being was powerful in "affirming their [the client's] normality" (Gega et al., 2013).

A safe, trusting environment

Participants in six studies described needing to feel safe and contained to be able to disclose symptoms and persevere during difficult therapy tasks (Clarke et al., 2004; Gega et al., 2013). This sense of safety developed through having trust in the therapist's expertise (5/9 studies); for example participants spoke of valuing the therapist's ability to "do a professional job" (Nilsson et al., 2007), remain calm

(Gostas et al., 2013; Nilsson et al., 2007) and have (and share) knowledge about symptoms (Gostas et al., 2013; Nilsson et al., 2007; Vincent et al., 2012).

In addition, clients felt that trust for their therapist was established by their therapist's ability to demonstrate "genuine concern" for them, "over and above their job" (Berg et al., 2008; Nilsson et al., 2007; Vincent et al., 2012). This was demonstrated by the therapist demonstrating empathy, being non-judgmental (6/9 studies) and showing willingness to adapt tasks to fit the needs of the client (Barnes et al., 2013; Berg et al., 2008; Gostas et al., 2013)

Collaboration

Clients in six studies spoke of the importance of being an equal partner in therapy; this was said to be demonstrated by the therapist being respectful of their preferences (Gostas et al., 2013; Vincent et al., 2012) and seeking their feedback about the usefulness of interventions (Clarke et al., 2004). However, clients also spoke about being happy to be "pushed" (Vincent et al., 2012), i.e. directed by the therapist, in the context of a respectful, supportive and collaborative relationship (identified in 6/9 studies).

Several clients across two studies (Barnes et al., 2013; Nilsson et al., 2007) reported that a lack of agreement with their therapist about the methods and goals of therapy, and a lack of therapist flexibility in the application of techniques, led to their feeling "restricted by the therapists fixed ideas" (Nilsson et al., 2007). One such client described how this led to dissatisfaction with the relationship and a sense that her therapist "did not really want to know about" her difficulties (Barnes et al., 2013).

The therapeutic journey: from doubt to belief

This domain describes participants' accounts of their journey through therapy, focusing on changes in clients' attitudes towards therapy and their beliefs about change, as well as clients' perspectives on the benefits gained from undertaking therapy.

Initial ambivalence about engagement

Clients in seven studies described feeling ambivalent about starting therapy, knowing that it would involve reflecting on difficult experiences and memories; clients in the majority of these studies were afraid that engaging in therapy might lead to difficult realisations, and believed that they would not be able to cope with these (Barnes et al., 2013; Berg et al., 2008; Clarke et al., 2004; Gostas et al., 2013). Indeed, in the initial stages of therapy, clients in several studies described the process as unusual and uncomfortable (Gostas et al., 2013; Vincent et al., 2012), and considered halting therapy because of this (Barnes et al., 2013; Vincent et al., 2012).

An additional source of ambivalence for clients was a belief that change was not realistic in the time available, and in view of the magnitude of their difficulties (identified in 5/9 studies). Some participants felt that even if change did happen, it would be very difficult to sustain (Berg et al., 2008; McManus et al., 2010). In addition, clients in two studies felt daunted on learning about the amount of their time, commitment and effort that would be required (Berg et al., 2008; Clarke et al., 2004).

However, as the therapy progressed, clients in the majority of studies (6/9) began to realise the benefits of therapy; clients experienced disclosure as cathartic (Berg et al., 2004; Vincent et al., 2012), and began to see signs of progress in themselves (Clarke et al., 2004; Gega et al., 2013; Nilsson et al., 2007; Vincent et al.,

2012). This "inspired trust and confidence" in the process (Gostas et al., 2013), and even when therapy did give rise to difficult feelings, clients described feeling able to accept this as part of the journey to getting better (Gostas et al., 2013; Vincent et al., 2012).

Recognition of self as agent of change

Clients in six studies described that initial beliefs about being a passive recipient of care changed dramatically as therapy progressed into "an awareness of one's self-agency and responsibility as a change agent" (Nilsson et al., 2007). As clients took more responsibility for change, they described learning that change is a gradual process that happens as change strategies are repeated over and over again (Clarke et al., 2004; Gega et al., 2013; Nilsson et al., 2007), rather than "some sort of magic treatment" (Gega et al., 2013) with instant effect. Clients reported that this awareness enabled them to feel independent and self-efficacious in relation to behaviour change, and engendered a sense of hope.

Benefits and realisations

Participants in nearly all studies (8/9) reflected on the ways in which therapy had positively impacted their lives. Participants in three studies stated that they were experiencing fewer symptoms by the end of therapy (Berg et al., 2008; McManus et al., 2010; Nilsson et al., 2007), whereas participant accounts in other studies emphasised that symptoms were exerting less of an influence in their lives, despite their continued presence (Clarke et al., 2004; McManus et al., 2010; Nilsson et al., 2007). In the majority of studies, participants described that feeling "more in control", and having greater acceptance of symptoms, resulted in feeling "less restricted" by them and functioning better (Barnes et al., 2013; Berg et al., 2008; Gega et al., 2013; McManus et al., 2010; Nilsson et al., 2007).

Additional changes following therapy included improved self esteem− feeling more self-confident and empowered (Gega et al., 2013; Clarke et al., 2004; McManus et al., 2010; Vincent et al., 2012)− as well as being kinder, more accepting and more compassionate towards themselves (Clarke et al., 2004; McManus et al., 2010; Nilsson et al., 2007). Importantly, these changes led clients to begin to "re-engage with the world" (McManus et al., 2010) through interacting more with others (Berg et al., 2008; Clarke et al., 2004; McManus et al., 2010; Nilsson et al., 2008), and being able to "envisage more optimistic possibilities" (Vincent et al., 2012) for the future (Gega et al., 2013; Vincent et al., 2012).

There were, however, some clients in two studies who provided less positive accounts (Nilsson et al., 2007; Vincent et al., 2012). Some felt that they had not improved as a result of therapy, or that it had only helped in the short-term (Nilsson et al., 2007). Others said that receiving help from mental health services signified that they had "failed" (Vincent et al., 2012) or were weak in some way (Vincent et al., 2012).

Discussion

This review synthesised findings from nine qualitative studies that examined clients' experiences of CBT interventions. On the whole, the studies were methodologically sound and yielded insights into the therapeutic processes of CBT, from a client perspective.

The synthesis demonstrated that clients valued the specific model-based techniques applied in the therapy, which, as described in many of the papers, clients felt increased insight into problem-maintaining patterns of thinking, feeling and behaving, and provided methods to overcome these. At the same time, the studies showed that clients attached great importance to the relationship with their therapists

and the safe, collaborative and supportive context that had been created in therapy. Furthermore, the synthesis shed light on clients' journeys through therapy, and the processes that enabled them to develop belief and confidence in their therapist, the methods of therapy, and their own capacity to effect change.

The three domains identified in the meta-synthesis reflect the theoretical tenets of CBT, i.e. that the purpose of therapy is to encourage insight into maladaptive patterns of thinking, feeling and behaving, and to aid the development alternative patterns though the application of cognitive and behavioural tools. Central to a CBT approach is the process of "collaborative empiricism" (Beck, 1995); this emphasises the active role of the client in the change process, and ultimately aims to empower clients to "become their own therapist" (Beck et al., 1979, p. 317; Dobson & Dobson, 2009). In addition, despite being felt by some to be understated, the therapeutic relationship has, since the evolution of cognitive therapy, been posited as integral to client progress. Beck stated that "the general characteristics of the therapist that facilitate the application of cognitive therapy… include warmth, accurate empathy and genuineness…" (Beck et al., 1979, p. 46), and "the degree to which the therapist is able to demonstrate these qualities, he is helping to develop a milieu in which the specific cognitive change techniques can be applied most efficiently" (Beck et al., 1979, p. 46). The above tenets are reflected in clients' accounts in the present review.

The findings from this meta-synthesis are consistent with qualitative meta-syntheses that have examined client experiences. In a recent meta-synthesis of client experiences of CBT for psychosis, Berry and Hayward (2011) identified two themes: the ingredients of therapy (comprising increased understanding of the onset of psychosis, and increased use of coping strategies) and the process of therapy

(encompassing clients' experiences of learning to accept oneself and one's psychotic experiences and an increased perception of personal power), which are similar to the themes identified in the current meta-synthesis. However in the Berry and Hayward (2011) review there is no mention of the therapeutic relationship. In view of the literature outlined above, it would be very surprising if this was because clients did not value the relational elements of therapy; it may possibly be that the purpose of the synthesis was to delineate solely the model- based components of CBT for psychosis, and the questions asked of participants and analysis reflected this (however this is unclear from the paper).

The current findings converge with research on client experiences of helpful events in non-CBT approaches. Timulak's (2007) qualitative meta-analytic study of a range of psychological therapies (including person-centred, experiential, psycho-dynamic, cognitive behavioural, family, solution-focused, and strategic therapy) identified nine core categories of helpful events, which he felt could be broadly grouped into the therapeutic relationship, the work of therapy, and empowerment and change.

Furthermore, the findings of the synthesis shed light on the association between the ingredients of CBT, namely the technical and relational factors. The studies demonstrated that for particular techniques, exposure for instance, a trusting, supportive relationship with the therapist was crucial to engagement. The reverse also appeared to be true; engaging with the techniques of the therapy, and experiencing the benefits of doing so, appeared to strengthen the therapeutic relationship. These findings suggest that it may be more fruitful to learn about the ways in which these factors inter-relate, as opposed to focusing on the issue of their relative importance (Castonguay & Holtforth, 2005).

In addition, the current meta-synthesis helped to illuminate some aspects of CBT that have received less attention in the literature. Formulation, for instance, despite being termed "the heart of evidence based practice" (Kuyken, Fothergill, Musa & Chadwick, 2005), ironically has very little evidence to show that it is efficacious (Beiling & Kuyken, 2003), or that clients experience it as a core part of CBT (Kuyken, Padesky, & Dudley, 2009). This meta-synthesis demonstrated that clients greatly valued the process of formulation because of the way in which it helped to normalise and increase insight into their difficulties, both of which enhanced belief in the possibility of change.

This review also sheds light on the issue of "what is a good outcome" in CBT. Many of the studies in this meta-synthesis noted that clients experienced the continued presence of symptoms post-therapy; however, in spite of this, their lives were now characterised by greater acceptance of symptoms and self, a perception of control over symptoms, and a sense of being less restricted and functioning better. This echoes study findings in the meta-synthesis of CBT for psychosis (Berry & Hayward, 2011): clients' accounts of change post-therapy emphasised "greater acceptance of their experiences of psychosis", and "an increased perception of personal power" in spite of there not necessarily being "an actual reduction in the frequency or distressing content of psychotic experiences" (Berry & Hayward, 2011, p. 491). In all, these findings indicate the need for a re-consideration of the way in which a good outcome is currently defined and measured.

Finally, the nine studies drew attention to the role of the client in therapy, such as client motivation and attitudes towards the change process, which tend to be overshadowed by an emphasis on what the therapist does in therapy (Cooper, 2008). The theme "recognition of self as an agent of change" described that as clients

became more actively involved in the therapy, and took more responsibility for change, they felt more self-efficacious and hopeful about making changes. Indeed, research suggests that client level of active involvement in therapy is possibly "the most important determinant" of outcome (Orlinsky, Grawe & Parks, 1994, p. 361). In summary, this meta-synthesis highlights the need to develop a better understanding about how to engage with client attitudes and beliefs to optimise the experience and outcome of therapy.

Limitations

One possible limitation of the meta-synthesis concerns the exclusion criteria; the question of this review was narrowly focused, excluding third wave approaches and other modes of delivery such as group or telephone assisted therapy, hence the results need to be considered within this context.

A challenge in conducting the meta-synthesis was the complexity involved in bringing together findings and identifying themes across primary studies underpinned by diverse research traditions, with slightly different foci to each other (and to the meta-question of the review), and adopting different analytic methods for making sense of participants' accounts. The aim was to highlight generality across the studies, whilst ensuring that this did not "destroy the integrity of the individual projects on which such summaries are based, to thin out the desired thickness of particulars" (Sandelowski et al., 1997, p. 366), which would have been contradictory to a qualitatively informed research endeavour. Therefore, attention was paid to differences in the data at the same time as identifying commonalities.

An additional challenge concerns the methodological appraisal of studies. There is a lack of consensus regarding whether a quality appraisal should be undertaken (Atkins, Lewin, Smith, Engel, Fretheim & Volmink, 2008), which

criteria should be used and the way in which these should be applied (Barbour & Barbour, 2003; Dixon-Woods, 2006; Dixon-Woods et al., 2004). In the current review, the CASP 10 questions for qualitative research (Critical Appraisal Skills Programme, 2002) were used flexibly as a set of guidelines, informed by a broader understanding of the core principles of qualitative research (CQMRG; Hannes, 2011), as opposed to checklist of criteria to be satisfied. A possible limitation of electing not to use the CASP as a tool to exclude studies that fell below a certain identified threshold in relation to methodological quality (the way in which it has been used in some previous studies; e.g. Carlsen Glenton & Pope, 2007), is that this may have resulted in the inclusion of studies with significant methodological shortcomings, calling into question the validity of findings. On the other hand, it is argued that a balance needs to be sought between the methodological flaws of a study, and the potential value that its insights and findings add to the overall synthesis (Edwards, Elwyn, Hood & Rollnick 2002). Indeed, there is ongoing debate as to whether quality appraisal should be used to exclude studies with poor methodological quality, and different researchers place differential emphasis on the "methodological soundness of studies" (Hannes, 2011). The CQRMG suggest that ultimately this decision lies with the researchers conducting the meta-synthesis (Hannes, 2011), but recommend that all researchers attempt to conduct sensitivity analyses, i.e. that they evaluate what happens to the findings of a study when low or high quality studies are removed (CQRMG, Hannes, 2011). In the present study, although greater weight was given to the higher quality methodological studies in an effort to improve the validity of findings, the study is limited by the fact that a formal sensitivity analysis was not conducted.

Despite this, the process of appraisal drew attention to the weaknesses in primary studies. Although the majority were methodologically sound, one prominent weakness across studies was the failure of authors to discuss how their prior understandings might have influenced the research process. This is a central tenet of qualitative research (Shenton, 2004) and it is recommended that future studies include these reflections.

Finally, the present review was limited by the fact that a single researcher appraised the quality of studies, selected the studies and conducted the analysis of primary studies. Although the researcher consulted with two experienced researchers throughout, the CQRMG (Hannes, 2011) recommend the involvement of more than one researcher during the process. It is suggested that future meta-syntheses give attention to these issues.

Research and practice implications

The findings of this review suggest a number of research and clinical implications. Firstly, there is a need for future studies to provide greater clarity about how the technical and relational factors of therapy interact, in order to gain a better understanding of the process of change. One way of doing this is to move from the general to the specifics of therapeutic encounters, i.e. to focus on the exchanges between client and therapist in therapy, to better understand how the various ingredients inter-relate and work at a micro level. Such research would have the benefit of not being limited by retrospective accounts of the therapy (unlike the studies within this meta-synthesis), and would provide meaningful clinical suggestions about how to modify practice to facilitate therapeutic change.

Furthermore, the findings show that research on client experiences can help illuminate the impact of therapeutic processes, such as formulation, that are less

amenable to being separated out from other components in therapy and examined independently through quantitative methods. The findings suggest that the process of formulation is an important ingredient of therapy from clients' perspectives, however future research needs to examine the impact of formulation on outcome in therapy, (Kukyen et al., 2005). It may also be of interest to examine differences in client experiences of idiosyncratic formulations versus the standardised manualised formulations. Further research on client experiences of formulation would ensure that formulation is used in ways that are experienced as helpful for clients.

In addition, there is a need to better understand what characterises a good outcome from a client perspective to enable the development of outcome measures that are relevant and meaningful for clients. The findings suggest that the markers of change traditionally emphasised within a medically oriented approach to mental health, i.e. symptom reduction, may result in a ''good outcome'' being defined too narrowly. Further research on client perspectives would ensure that measures of change are meaningful for clients.

In relation to clinical practice, given that the therapeutic relationship and technical factors are both important, therapists need to ensure that equal attention is paid to both in the therapy. This may be particularly important when training in the more directive, skill-based therapies where there may be a risk of relationship factors being downplayed.

In addition, the findings highlight the need for therapist to appreciate that clients may require clearer explanations, and more time to understand instructions and the rationale for tasks and homework, particularly in relation to the more complicated cognitive techniques. In general, the findings point to the importance of

the therapist being cognisant of the client's level of understanding and preferences, and adapting the tasks of therapy in response to these.

Finally, the findings about client attitudes and beliefs indicate a need for therapists to assess clients' expectations of therapy and the change process, and to help clients develop realistic expectations, by providing them with a clear understanding of their role and the level of commitment required early on in the therapy. Related to this, it would beneficial for therapists to explore and address client hesitations and concerns early on in the therapy to prevent these from becoming barriers to engagement with the treatment.

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Part 2: Empirical Paper

Clients' experiences of cognitive restructuring techniques:

A tape-assisted recall study.

Abstract

Aim: Previous studies of clients' experiences of CBT have relied on global retrospective accounts; little research has examined experiences of specific therapist responses in the process of actual interactions. This study used the method of Tape-Assisted Recall (TAR) to examine clients' perceptions of specific therapist responses in the delivery of cognitive restructuring techniques, in order to improve our understanding of the contexts within which certain responses or interventions are most helpful.

Method: Ten clients receiving CBT at a university-based psychological service participated in a TAR interview, in which their moment-to-moment reactions to the therapist's responses were explored in detail. Transcripts from the TAR interviews were analysed using thematic analysis (Braun & Clarke, 2006).

Results: Cognitive restructuring techniques (identifying maladaptive cognitions, identifying and labelling cognitive biases, and disputing maladaptive cognitions) were experienced as helpful when they were delivered in the context of an empathic and trusting therapeutic relationship and when clients were guided to discover alternative perspectives for themselves. Unhelpful therapist responses were characterised by therapists challenging clients' perspectives before understanding, and being overly directive.

Conclusion: Clients' accounts demonstrated that it was not the techniques per se that determined their experiences of cognitive restructuring techniques but the context of the therapeutic relationship within which they were delivered. The findings were generally consistent with clinical practice guidelines. The TAR methodology provides a valuable way of understanding the specific nature of therapeutic interactions and may have potential as a clinical tool.

Introduction

Cognitive behaviour therapy (CBT) is one of the most widely practiced of the psychotherapies, and there is large body of evidence supporting its efficacy and effectiveness for a range of psychological disorders (Hollon & Beck, 2013; Merrill, Tolbert & Wade, 2003; Westbrook & Kirk, 2005). Increasingly researchers have recognised that as well as establishing that a treatment works, it is crucial to understand "for whom and under what conditions they work, how they work and why they work" (Laurenceau, Hayes & Feldman, 2007, p. 683), in order to refine and develop treatments to maximise therapeutic outcomes.

Despite a growing interest in the process of change in CBT, however, the mechanisms of change continue to be unclear (Bennett-Levy, 2003), and there is considerable controversy about the extent to which the mechanisms proposed by CBT theory account for the effects of treatment (Clarke, 2013; Hayes, 2004; Longmore & Worrell, 2007). For instance, a fundamental tenet of the cognitive therapy component of CBT is that psychological problems are a consequence of dysfunctional cognitions, hence "correction of these faulty dysfunctional constructs can lead to clinical improvement" (Beck, Rush, Shaw & Emery, 1979, p. 8) through a process of identifying, evaluating and modifying their meaning (Beck et al., 1979).

In line with this, CBT treatment manuals typically emphasise techniques aimed at modifying or restructuring clients' maladaptive cognitions, including identifying and evaluating distorted patterns of thinking, evaluating evidence for and against a thought, and generating alternative thoughts (Beck & Emery, 1985). In addition, a review of processes and techniques in different psychotherapies found that focusing on the client's cognitive experience, i.e. identifying and challenging irrational thoughts and beliefs, was a key process that distinguished CBT practice

from other psychotherapeutic approaches (Blagys & Hilsenroth, 2002), suggesting that cognitive restructuring is a hallmark of CBT practice.

However, the empirical evidence to support this "principal practice" (Clark, 2013) is mixed (Hayes, 2004; Longmore & Worrell, 2007). In support of the effectiveness of cognitive strategies, studies have found that their use leads to positive outcomes compared to control conditions (Dickerson, 2000), and that there is a positive correlation between the use of cognitive techniques early on in therapy and subsequent improvement (DeRubeis & Feeley, 1990).

On the other hand, there is a significant body of research demonstrating that symptom improvement in CBT is unrelated to the application of cognitive techniques (Jacobsen et al. 1996; Hayes, 2004). Component analyses have shown that the addition of cognitive components of CBT do not add to the effectiveness of treatment (Gortner, Gollan, Dobson, & Jacobson, 1998; Jacobsen et al., 1996), and some studies have shown that "clinical improvement in CBT often occurs before the presumptively key features have been adequately implemented" (e.g. the finding of "the rapid early response" Hayes, 2004, p. 5).

The research summarised above comprises pre-post treatment design studies and component analyses in which components of CBT are examined separately to delineate the most efficacious therapeutic elements (see Longmore & Worrell, 2007, for a review). Although such studies have begun to address the question of which components of change are important, the findings are inconclusive (Bennett-Levy, 2003). Moreover, these studies are based on the assumption that interventions are delivered in a uniform way, and that all clients change in the same way (the "uniformity myth"; Kiesler, 1966). In fact, there is a significant body of research demonstrating considerable variability between therapists practicing within the same

manualised approach (for reviews, see Beutler, Machado & Neufeldt, 1994; Lambert, 1989), and there is an increasing recognition of the important role that therapist, client and therapist-client relational factors play in moderating change in CBT. Research has demonstrated that the therapeutic relationship and therapist factors (e.g. therapeutic alliance, therapist empathy, therapist training, therapist competence), and client characteristics (e.g. expectations, perceived mastery, willingness to engage) contribute significantly to CBT treatment outcome (Burns & Nolen- Hoeksema, 1992; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Hoberman, Lewinsohn, & Tilson, 1988; Webb, DeRubeis & Barber, 2010).

Qualitative methods provide another avenue by which to explore the complex processes that underlie effective therapeutic interventions (Elliott, 2010; McLeod, 2011, 2013; Pistrang & Barker, 2010). In contrast with quantitative methods, these enable the in-depth study of participants' subjective experience of therapy, and hence are well suited to explore the complexities and finer details of the therapy process (McLeod, 2013). The client's perspective of therapy has traditionally been overlooked in research due to a longstanding belief that their "dysfunctionality" (Lambert, 2013, p. 247) leads them to be unreliable reporters of their experience (Hodgetts & Wright, 2007). Certainly, a large body of research demonstrates that memory recall is subject to distortion by various cognitive and emotional processes, such as individual perceptions and beliefs, social influences, and world knowledge, which can often result in errors during recall or reconstruction (Vicente & Brewer, 1993).

Notwithstanding this, there are strong arguments as to why clients' perspectives can make a valuable contribution to psychotherapy research and practice. In a review of the psychotherapy literature, Orlinsky, Ronnestad and

Willutzki (2004) suggested that the therapeutic alliance, particularly as viewed by the client, is a key determinant of therapy outcome. It is argued therefore that we can better understand the process of therapy if we study the kinds of experiences clients have in therapy (Elliott & James, 1989).

A small number of promising qualitative studies exploring clients' perspectives of CBT have made a valuable contribution to our understanding of the process of therapy. Part 1 of this thesis presents a meta-synthesis of nine qualitative studies that examined clients' experiences of individual CBT. The main findings were that clients valued both the behavioural and cognitive components of CBT, as well as the collaborative, relational bond with their therapist, which enabled them to feel safe and contained to engage in the task of therapy.

Clients' accounts in these studies provide useful information about their experiences of cognitive interventions. For example, thought challenging exercises were perceived as helpful, with clients reporting that they noticed the positive impact these had on their perceptions and their responses to difficult situations (Barnes et al., 2013; Berg, Raminani, Greer, Harwood & Safren, 2008; McManus, Peerbhoy, Larkin & Clarke, 2010). With regards to the specific tools introduced to facilitate cognitive restructuring, client accounts were mixed: for example, some participants perceived working through the structured cognitive record sheets to be particularly helpful (Clarke, Rees & Hardy, 2004; McManus et al., 2010), whereas others described the cognitive work as too abstract (Ayers, Bratiotis, Saxena & Wetherell, 2012; Berg et al., 2008; Barnes et al., 2007; McManus et al., 2010).

Although these studies have made an important contribution to our understanding of what clients perceive to be the important ingredients of change, they are limited by the fact that they examine clients' retrospective accounts of

therapy, which raises issues about the accuracy of recall (discussed above). Moreover, their focus on the general aspects of the therapy, i.e. at the level of the intervention, as opposed to the level of specific individual therapist behaviours or responses within actual interactions, provides little information about the interactional nature of therapy and how intended responses and techniques are experienced by clients.

Indeed, McLeod (1994) describes one of the main challenges of qualitative psychotherapy process research as that of devising a way of getting into "the interior of therapy" (p. 147), and gaining access to important experiential detail about clients moment-by-moment perceptions of the therapy process. He argues that this level of enquiry can provide a more fine-grained picture of the change process. Researchers need to understand and specify "which specific therapist interventions, introduced in which momentary therapeutic contexts will lead to which immediate and subsequent impacts (outcomes) for the client" (Stiles, Shapiro & Elliott, 1986, p. 174).

Cognitive behavioural treatment manuals typically draw attention to the interactional aspects of the delivery of specific techniques. For instance, Beck et al. (1979), in their guidelines for asking questions in cognitive therapy recognise that a question is: "an important and powerful tool for identifying, considering and correcting cognitions and beliefs" (p. 71), but warns that a client might feel "that he is being cross-examined or that he is being attacked if questions are used to trap him into contradicting himself" (p. 71). He goes on to say that "questions must be carefully timed and phrased so as to help the patient recognise and consider his notions reflectively" (Beck et al., 1979, p. 71). However, there is very little research examining specific therapist behaviours/responses in the process of actual interactions.

Tape-Assisted Recall

Unlike retrospective self-report studies, the Tape-Assisted Recall approach (formerly known as Interpersonal- Process Recall; Elliott, 1986; Kagan, 1980) is a well-established method designed to access the participant's experience as close as possible to the actual interaction. It involves recording a conversation, and playing it back to one or both participants within 48 hours of the recorded conversation to elicit their detailed reactions to the conversation (Elliott, 1986). It is described by Mcleod (2001) as the "jewel in the crown of psychotherapy process research" (p.81) because it enables access to the client's conscious but unspoken experiences at the time of the interaction, which are not accessible using other methods. Furthermore, playing the recorded session back to the client provides retrieval cues for recall, resulting in it being a more powerful method than free recall, and carrying out the recall procedure within 48 hours of the session capitalises on the recency effect, thereby making memories more accessible (Elliott, & Shapiro,1988).

This method has been used most commonly to study client-therapist interaction within psychotherapy (Elliott, 1986; Rennie, 1992) with regards to a range of phenomena: clients' deference in psychotherapy (Rennie, 1994), disengagement in sessions (Frankel & Levitt, 2009), clients' perceptions of silence (Levitt, 2001) and clients' experiences of positive and negative significant events in therapy (Elliott et al., 1994). It has also been used to study patients' experiences of GP consultations (e.g. Buszewicz, Pistrang, Barker, Cape & Martin, 2006; Cape et al., 2010) and in studies of informal helping within couples (Pistrang, Picciotto & Barker, 2001). This methodology clearly has practical implications for supporting

therapists to build specific competencies to improve the effectiveness of their interventions.

The present study

In view of the controversy around the empirical basis for cognitive interventions and clinical observations that the delivery of these can significantly affect how they are experienced by clients, the present study used Tape-Assisted Recall (TAR: Elliott, 1986; Elliott & Shapiro, 1988) to examine clients' experiences of cognitive restructuring techniques, with the aim that this would contribute to a better understanding of the "momentary therapeutic contexts" (Rice & Greenberg, 1984, p. 174) within which they were experienced by clients as helpful or unhelpful

There are various descriptions in the literature of the kinds of techniques that are commonly utilised to achieve cognitive restructuring (Clark & Beck, 2010; Dobson & Dobson, 2009). This study examined cognitive restructuring techniques that aimed to "identify, evaluate and modify the faulty thoughts, evaluations and beliefs that are considered responsible for their psychological disturbance", such as the "downward arrow" technique for identifying core beliefs and the identification of evidence for and against a thought (Burns & Beck, 1978; Dobson & Dozois, 2010).

The procedure was that extracts of clients' therapy sessions containing cognitive restructuring techniques were played back in a TAR interview, and clients were then asked about their moment-by-moment experiences of these. The aim was to obtain a detailed understanding of the specific processes that occurred during the interaction as it unfolded.

The central research question was: How do clients experience the delivery of commonly used cognitive restructuring (CR) techniques?

Method

Setting

The research was conducted in a university-based psychological service that offered a range of services for students, including individual and group psychotherapy and counselling, and personal development workshops. The staff team comprised psychiatrists, counsellors, CBT therapists and psychodynamic therapists. Referred (or self-referred) clients were offered an initial consultation appointment, after which they were put on a waiting list for one of the therapeutic options offered in the service. Clients offered individual CBT received on average six 50-minute sessions.

Ethical approval

Ethical approval was given by the UCL ethics committee (approval letter in Appendix A)

Recruitment

Clients were eligible for the study if they:

1) were an undergraduate or postgraduate student aged at least 18 years

2) had attended at least one session of individual CBT.

Clients whose presenting problem was psychosis or severe substance misuse problems were excluded.

CBT therapists were asked permission for their clients to be recruited for the study. "CBT therapist" was defined as a counsellor or therapist who had undertaken training in CBT and who was currently delivering CBT interventions. Each therapist was requested to invite all new, consecutive clients to participate until four expressed an interest in participating (see Appendix B for therapist instructions and Appendix

C for recruitment flyer). Interested clients were telephoned by the researcher to screen for suitability and to provide further information about the study. A participant information sheet was provided for all potential participants to read before deciding on whether to participate (Appendix D), and written informed consent was obtained (Appendix E).

Therapists of clients who consented to participate in the study were asked to audio-record their client's third or fourth therapy session. After their session, clients were contacted to arrange the Tape-Assisted Recall interview, with the aim for this to take place within 48 hours of their therapy session. This was achieved for the majority of interviews, with the exception of two that took place four days after the therapy session, and one that took place five days afterwards, due to the clients' unavailability.

Four therapists agreed to aid recruitment for the study, and a total of 12 clients expressed an interest in participating in the study. One declined because he was not able to attend the interview within the time-period required, and another declined because she felt that participation might be too distressing. The 10 remaining clients participated.

Participants

Table 1 presents characteristics of the 10 participating clients. There were six men and four women with a mean age of 22 (range: 20-28). All but two self-identified as presenting with anxiety or depression. The exceptions were a client who presented with "relationship difficulties" and a client whose presenting issue was the result of a friend's traumatic experience. All clients had attended between three and five therapy sessions, and the majority (eight) had had previous experience of therapy.

Table 1

Characteristics of participants

Client ID	Sex	Presenting problem	Sessions attended	Therapist ID	Previous experience of therapy
C1	F	Depression	4	A	Yes
C2	M	Low mood	5	B	Yes
C3	M	Low mood	5	B	Yes
C4	M	Anxiety	4	B	No
C5	M	Anxiety post head injury	4	B	Yes
C6	F	Friend's trauma	4	C	No
C7	M	Anxiety, low mood	3	A	Yes
C8	M	Relationship difficulties	3	D	Yes
C9	F	Anxiety and low mood	3	D	Yes
C10	F	Anxiety and eating disorder	4	A	Yes

Five participants described themselves as White/ White British, two as Asian British, one as White other, one as Chinese, and one as Hispanic. Seven were home students, one was an EU student, and two were non-EU students. They were studying subjects from a range of faculties; all but three were undergraduates.

The four therapists were accredited CBT therapists with on average six years of experience (range= 3-10 years). Three of the four were women, and they had a mean age of 38 (range: 33- 48 years).

Procedures

Figure 1 shows a flow chart of the study procedures. Therapists of consenting clients were asked to record their client's upcoming therapy session. The researcher then reviewed the recording and selected extracts to be played back in the TAR interview. The researcher met with participants approximately two days after their therapy session for the TAR interview. Prior to the interview, participants first completed a demographic questionnaire (Appendix F) and the Working Alliance Inventory (Tracey & Kokotovic, 1989).

On completion of the TAR interview, clients were debriefed and given the opportunity to reflect on their reactions to the interview and their experience of their involvement in the research. The entire procedure took between 60 to 90 minutes and participants received reimbursement of £10 plus travel expenses as a token of thanks for their time.

Figure 1

Overview of study procedures

```
┌─────────────────────────────────────────┐
│        Client is recruited by therapist  │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│   Client gives consent to participate    │
│              in study                     │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│    Researcher asks therapist to record   │
│              therapy session              │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│    Researcher reviews recording and      │
│              selects extracts             │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│    Researcher contacts client to arrange │
│              TAR interview                │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│   Researcher meets with the client for   │
│           the TAR procedure:              │
│                                           │
│   • Questionnaires are completed          │
│   • TAR interview takes place             │
│   • Debrief                               │
└─────────────────────────────────────────┘
```
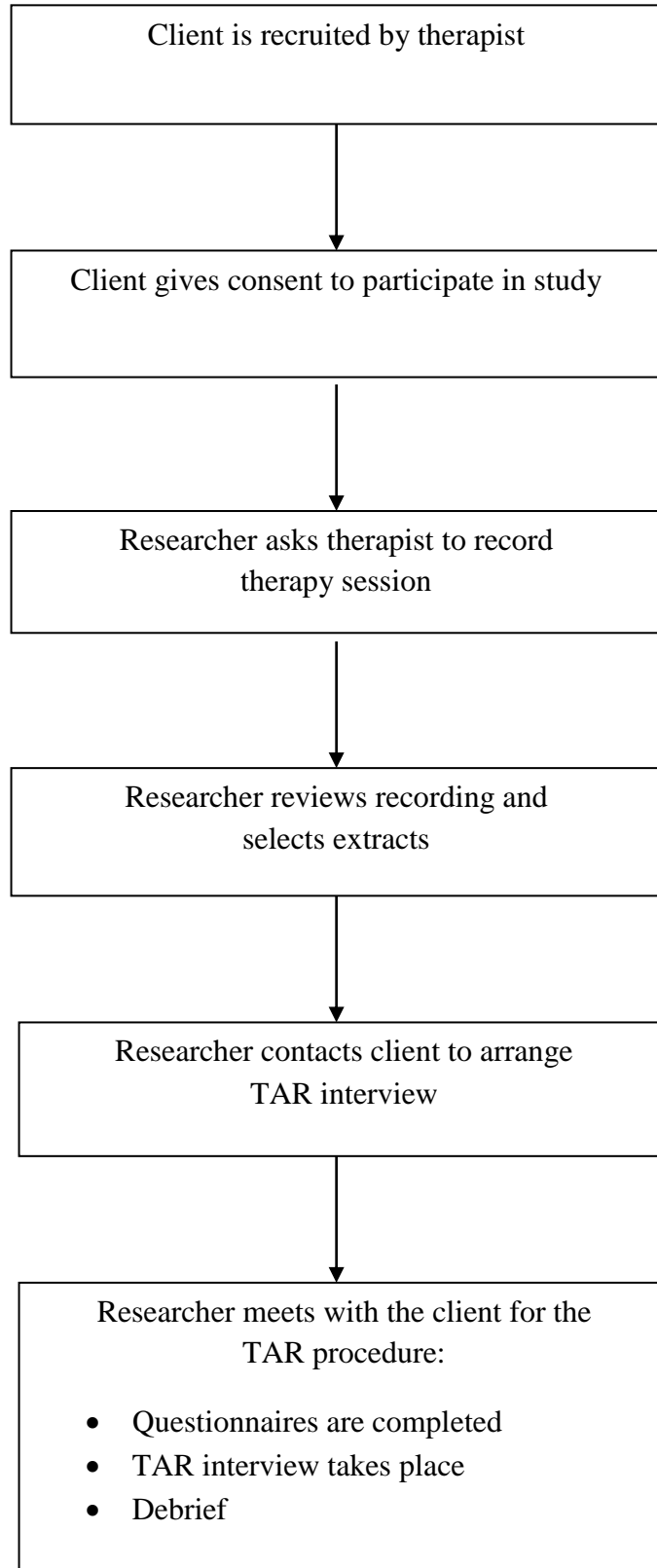
Tape-Assisted Recall procedure

The TAR (Elliott, 1986; Elliott & Shapiro, 1988) procedure involved the researcher first selecting extracts from the client's audio-recorded therapy session and then playing these back in the TAR interview to elicit his/her detailed reactions to them.

Selection of therapy extracts

Prior to the TAR interview, the researcher listened to the recording of the client's session and then re-played it to select extracts in which the therapist employed cognitive restructuring techniques. The techniques chosen could vary in length and could be formed of a single therapist response (e.g. a Socratic question), a short series of therapist responses (e.g. the "downward arrow" technique) or a longer series of therapist responses in the service of a broader activity (e.g. identifying evidence for and against a thought).

The literature on commonly used CR techniques (Clark, 2013; Clark & Beck, 2010) was consulted to aid the selection of appropriate extracts. CBT techniques that did not fall under the umbrella of cognitive restructuring, including behavioural or experiential tasks (e.g. behavioural activation and exposure tasks) and third wave CBT techniques (e.g. mindfulness exercises) were not selected.

Given that it was expected that there would be too many CR techniques for all of them to played back in the TAR interview, those that occurred closest to the time points 5, 20, 35 and 50 minutes were selected. During the TAR interviews, clients were also offered the opportunity to select three or four extracts that they identified as salient (i.e. particularly helpful or unhelpful). Only one client identified a salient extract; however this had already been selected by the therapist to be played back.

TAR interview

A semi-structured interview schedule (Appendix G) was developed, based on one that was used in a previous TAR study (Pistrang, Picciotto & Barker, 2001). To begin with, the researcher asked the participant some general questions about their experience of their therapy session (e.g. "Overall, how helpful or unhelpful was the therapy session for you?"), and asked them to rate their therapy session on a 6-point scale (1= "Very unhelpful", 6= "Very helpful").

The participant and researcher then listened to the four selected extracts. For each extract, the participant was asked which aspects of the interaction were experienced as helpful and which as unhelpful, and was then asked in detail about their reactions to the therapist's responses. Drawing on guidelines for interviewing in qualitative research (King & Horrocks, 2010), a funnel approach to questioning was employed, starting with fairly broad open questions e.g. "What was it like for you at that point in the session", to increasingly focused questions and follow-up probes as the interview progressed, e.g. "What was it about what your therapist said then that you found particularly helpful?". The aim of this was to ensure as much as possible that the researcher's views did not influence interviewees' responses.

Working Alliance Inventory

The Working Alliance Inventory- Short Form (WAI-S; Tracey & Kokotovic, 1989; Appendix H) was administered to provide contextual information about the clients' perceptions of the therapy. The WAI-S measures the quality of the therapeutic relationship between client and therapist. It consists of 12 items (sample item: "I feel that my therapist appreciates me") scored on a 7-point Likert scale (ranging from 1 = Never to 7 = Always). It has a general scale (General Alliance)

and three subscales: therapeutic bond, agreement on tasks, and agreement about goals.

The WAI-S has an internal consistency, ranging from .70 to .91 for the subscales, which is in the acceptable to good range, and .90 to .95 for the general scale (Busseri & Tyler, 2003; Dunkle & Fridlander, 1996; Ligiero & Gelso, 2002). It has satisfactory test re-test reliability of .83 (Horvarth, 1994) and acceptable predictive and concurrent validity (Ligiero & Gelso, 2002; Parish & Eagle, 2003).

Data Analysis

Prior to the analysis of the clients' accounts, it was necessary to first cluster the cognitive restructuring techniques played back in the TAR interview, in order to simplify the process of linking themes to the techniques. Hence, the extracts that were the focus of the TAR were first coded based on the aim of the cognitive restructuring technique employed. Techniques with codes representing similar aims were then clustered together. This process yielded three clusters of techniques: (1) identifying maladaptive cognitions (2) identifying and labelling cognitive biases and (3) disputing maladaptive cognitions. Although clusters 1 and 2 are linked in that they both involve the identification of cognitions, in the CBT literature a distinction is commonly made between them on the basis that the former involve helping clients to observe and record the cognitions that arise in specific situations, and the latter involve helping clients to observe and label their biases in information-processing (Beck, 1967; Westbrook, Kennerly & Kirk, 2011).

The next stage was the analysis of clients' accounts of the impact of each of the techniques (i.e. the data from the TAR interview). Transcripts from the TAR interview were analysed using Braun and Clarke's (2006) approach to thematic analysis. This approach was chosen because it is pan-theoretical and has the potential

to provide a rich and detailed account of data (Braun & Clarke, 2006). For each CR technique, the client's account of the impact of the technique was the focus of analysis. An example of the key stages of the thematic analysis is presented in Appendix I.

To begin with, the researcher became familiar with the data set by reading through each transcript several times and making notes of initial patterns and meanings. Second, the researcher generated a preliminary list of all the features of the data related to clients' descriptions of the impact of therapists' responses for each technique. This was followed by an initial coding process in which tentative codes were given to the data. Next, the researcher generated a list of the codes identified in participants' accounts and began a preliminary process of sorting codes into potential themes.

Once this process had been undertaken for each transcript, codes and themes were compared across transcripts and combined to form over-arching themes. This was an iterative process and included re-reading the transcripts for context and intended meaning. Finally, themes were named and defined, and their impact was coded as helpful, unhelpful or mixed based on participants' accounts. The decision about which themes to include were based on the importance they held in clients' accounts, rather than on frequency.

Credibility checks

In order to ensure the trustworthiness of the analysis, credibility checks were carried out (Willig, 2013). At each stage of the analysis, the data analysis procedure was discussed in-depth with two supervisors experienced in qualitative research. Once a set of preliminary themes was put together, these were discussed and reviewed with both supervisors to ensure that they were organised in a meaningful

way, and that the labels for themes captured the essence of what each theme was about (Braun and Clarke, 2006). These discussions led to some changes to the labelling and classification of themes.

In addition, at the preliminary stage of analysis, respondent validation was used as a further credibility check, whereby the researcher asked participants for feedback on a summary of the main ideas expressed in their interview, to determine the accuracy of the researcher's interpretation. An excerpt from the summary of one participant's interview is shown in Appendix J. All of the five participants who responded to the request for feedback felt that the summary fit "very well" with their experiences.

Researcher's perspective

Given that the researcher's values, beliefs and personal characteristics inevitably have a bearing on the processes of data collection and interpretation, I have attempted to make these explicit below so that the reader can judge the interpretations made and the conclusions drawn (Barker & Pistrang, 2005).

I am a 26 year old, British Asian (Indian) woman from a middle-class background and I conducted this research in my second and third year of a doctorate in Clinical Psychology. My interest in clients' experiences of therapeutic interventions initially arose in my first year clinical placement in an adult community mental health team, where I had a supervisor who was very person-centred and committed to learning from clients about how to improve his practice. This encouraged me to hold a curiosity in my own clinical practice about what aspects of therapeutic encounters were of benefit.

At the time of conducting the research, I had five years of experience in delivering CBT with a range of client populations and in varied settings. My

experiences of CBT led me to have some pre-conceptions about what clients might find helpful and what they might find unhelpful. I generally have had a positive experience of delivering CBT; however I have always wondered about how clients experience the inherently difficult process of their world-views being challenged, and the use of language (for example the term "distorted") commonly used to describe thinking. I have also wondered about how clients' reactions to these processes may change depending on the quality of the therapist-client relationship.

In addition to my CBT leanings, I have a particular affinity with person-centred approaches because I feel that they are underpinned by values and principles that resonate with my own spiritual beliefs and my preferred world-view (e.g. belief in the individuals' natural self-healing process, the centrality of genuineness, warmth, acceptance and non- judgmentalism).

I attempted to remain aware of my pre-conceptions during the research by acknowledging their presence and reflecting on the ways in which they might be influencing various aspects of the research process, particularly at the interview and data analysis stages.

Results

The results are presented in three parts. First, a brief overview is given of clients' experiences of their therapy, including descriptive data on the Working Alliance Inventory (Tracey & Kokotovic, 1989). The second, main section presents the themes from the TAR interview focusing on clients' experiences of cognitive restructuring techniques. Finally, some themes that address broader aspects of clients' experiences, i.e. those not linked to cognitive restructuring techniques, but that were salient for clients, are reported.

Overview of clients' experiences of therapy

Participants were generally positive about their experiences of therapy. The majority spoke about noticing changes in the way they were managing their difficulties compared with when they first came to therapy, and they reflected on "realisations" (C2) they had come to, and new "skills" (C2) they had learned thus far. In general, clients described feeling a sense of "accomplishment" at having "made progress" (C1) in overcoming their difficulties.

There was one client (C8), however, who reported gaining very little from therapy. He felt that he and his therapist were working towards different goals, his being to discover the cause of his difficulties, and his therapist's being for him to solve a dilemma he was facing. In addition, he reported feeling like "a case study", because he perceived his therapist to be relying solely on her "professional knowledge" without taking into account "knowledge from the actual situation". This left the client feeling that he was "not getting what [he] wanted from therapy" (C8).

Participants' ratings of the session indicated that clients experienced their sessions as moderately helpful (mean= 3.8, range= 2-5). Similarly, the scores from the Working Alliance Inventory (Tracey & Kokotovic, 1989) indicated that there was a strong working alliance between clients and therapists in the study (mean= 66.9, s.d = 11), consistent with clients' experiences reported above. The one client who described being dissatisfied with his experience of therapy, scored notably lower than the other clients on this measure (40).

Clients' experiences of cognitive restructuring (CR): themes from the TAR

The three clusters of CR techniques, their associated themes, and their impacts ("helpful", "unhelpful" or "mixed") are shown in Table 2.

Table 2. Themes for each cluster of CR techniques.

Cluster of cognitive restructuring (CR) techniques	Themes	Impact	Frequency
1. Identifying maladaptive cognitions	1.1 Reflecting back my feelings	Helpful	9
	1.2 Asking broad, unspecific questions	Unhelpful	4
	1.3 Creating an atmosphere of trust and safety	Helpful	9
	1.4 Portraying my beliefs as unchangeable	Unhelpful	2
2. Identifying and labelling cognitive biases	2.1 Pointing out my thinking habits	Helpful	3
	2.2 Providing a label	Helpful	3
3. Disputing maladaptive cognitions	3.1 Challenging before understanding	Unhelpful	4
	3.2 Allowing me to discover for myself	Helpful	6
	3.3 Helping me to analyze the implications of my beliefs	Helpful	2
	3.4 Disagreeing with my point of view	Mixed	3

Note. Frequency refers to the number of transcripts within which themes were

present

The themes capture the way in which the CR techniques were carried out. The themes associated with each cluster of CR techniques will be presented in turn. Each theme is illustrated by excerpts from the therapy session itself (in bold text) and clients' accounts from the TAR interview of the impact the response had on them (in italic text). Alpha-numerical participant IDs are used to distinguish between the client (C1), the therapist (TA) and the researcher (R). An asterisk (*) is used to denote the specific therapist response relevant to the theme. The term "therapist response" is used to refer to an individual talking turn and the term "technique" is used to refer to a short series of therapist responses or a longer series of therapist responses in the service of a broader activity (e.g. identifying evidence for and against a thought).

CR technique cluster 1. Identifying maladaptive cognitions

The CR techniques included in this cluster were those that aimed to identify clients' negative automatic thoughts, evaluations and underlying beliefs, considered responsible for their psychological distress (Clark, 2013). The specific techniques employed by therapists included: eliciting idiosyncratic meaning, thought recording and the "downward arrow" technique to identify core beliefs.

Theme 1.1: Reflecting back my feelings

All but one client reported that the therapist reflecting back their feelings was a positive experience (the exception to this, C10, found it unhelpful because she found that it intensified her feelings). Therapist responses included under this theme were characterised by the therapist reflecting the client's hitherto unspoken feelings, thereby communicating to the client that he/she understood the client's internal emotional experience. Therapists typically did this in the early stages of cognitive restructuring when they were encouraging the client's exploration of a given problem

situation, in order to facilitate identification of the cognitions that were responsible for their distress.

Clients reported several positive impacts of the therapist reflecting their feelings. Firstly the process of feeling understood was a highly affirming experience that led clients to feel that the therapist was "truly interested" (C7) and genuinely engaged in their story. Moreover, hearing their feelings articulated in words that accurately reflected how they were feeling enabled them to access the emotions that they had experienced at the time of the situation, which was the first step to being able to access their thoughts.

In the excerpt of the therapy session below, C1 disclosed a recent situation involving her sister which left her feeling frustrated and annoyed. The therapist, through active listening and empathic reflection summarised the client's emotional response to the situation, and developed a hypothesis about the client's underlying assumption, which he shared with the client (the key therapist's response is marked by an asterisk).

> **C: Whenever I disrupt what she [sister] perceives to be the correct way things go, which is I just do what she says, she gets instantly really really defensive**
> **T: Mmm**
> **C: And I guess, like we were saying last time, maybe she is insecure, but she tries to get over that by completely controlling me and then I don't want that. It feels quite hard really.**
> **T: Yeah. So I'm getting the sense of you feeling that she's basically got this power over you to make you feel crap.**
> **C: Yep**
> **T: To punch you in the stomach and take the wind out of your sails**
> **(C laughs)**
> **C: Yeah**
> **T: And you feeling that you've now stepped out of line by going against her pre-ordained plans.**
> **C: Yeah**
> ***T: I'm wondering, is there like a sense of not having the right to assert yourself?**
> **C: Yeah that sounds kind of. Yeah very much actually. That kind of makes a lot of sense actually.**

In the TAR interview, C1 described how the therapist's response resonated with how she was feeling. This helped her to feel understood, and to be guided towards a deeper level of understanding about the assumptions underlying her emotional response to the situation. This in turn helped her to begin to understand how different aspects of her problem fit together.

> *It got the sense of what I was feeling in terms of, punched in the stomach and wind out of your sails. That very much describes what I was trying to put across to him, and then when he said "I've got the sense that you don't have the right" I was like..actually that's it!, that's what I've been trying to [get across]. So I found that quite helpful because if you can have ideas, words or concepts put to thoughts in your head it's obviously quite helpful. In terms of how I was feeling? I was feeling things slotting into place. (C1)*

Theme 1.2: Asking broad, unspecific questions

Broad, unspecific questions were experienced as difficult to respond to, and often took the session in an unfruitful direction. Clients reported that the process of discovering their underlying beliefs was inherently quite difficult, because "how [they saw] themselves" (C6) was not something that they had generally given a lot of thought to. This process was felt to be even more challenging when clients were not given enough guidance and "direction". For example, C9 and her therapist were discussing the client's tendency to "busy herself", and the therapist asked a question to explore the underlying cognitions:

> **T: OK this might actually lead into what I was talking about in terms of being this busy. And what sort of thoughts are behind that? Is there a kind of rule around keeping busy and the purpose?**
> **C: (silence)**
> ***T: In terms of your schedule and just how busy you are with things. What do you think that's about for you?**
> **C: Erm..(silence)..I mean the thing with the work is. I guess this needs unpicking as well but I'm also really terrible with money. And it doesn't matter how many jobs I have I'm always spending a little bit beyond my means.**

In the TAR, C9 explained that the therapist's question "what's that about for you?" was too broad and open-ended, and resulted in her responding with an equally broad response:

> C: *It's such an open-ended thing I'm a bit like...how do I answer that? It's a huge question, and I end up going on tangents about various different things that might be the cause*
> R: *At the point that she asked the question, were you aware that you went off on a tangent?*
> C: *I think I was trying to answer and to do so you have to go in various directions and I find it too broad and don't really know what to do with it.*

Similarly, when C6 was asked by her therapist about how she thought a new discovery they had made in the session fitted with "how she saw herself", she found this to be a "very big question" and felt she "could really go off topic here". C6 suggested that a more helpful approach would have been to ask "*a couple of more detailed or specific questions, rather than just..like..who you are as a person sort of thing...for me I'd probably find it easier to answer a specific question*" (C6). In line with this, another client (C5) spoke about how he was able to better engage with the exercise of identifying his belief, when the therapist prompted and suggested ideas about his beliefs based on what he had learned about her from the session.

Theme 1.3: Creating an atmosphere of trust and safety

Nearly all clients described the process of expressing and articulating difficult thoughts and feelings "out loud" as helpful, but also uncomfortable. Clients spoke about the importance of the therapist creating a sense of safety, and "comfort" in the therapy where difficult thoughts and feelings could be expressed. C5, for example described his initial reluctance to articulate his core belief:

> *I remember it was quite difficult to say initially because that thought, that my mind has been broken, is a thing that I've thought about a lot and it's how I think about myself but I've never said that to anyone so um...I was hesitating because....I don't know why necessarily I think it's because it's just quite a*

strong phrase and saying it out loud which I'd never done before was difficult(C5).

C5 went on to specify that feeling comfortable with his therapist, and a belief that she would be able to help is what enabled him to proceed with articulating the belief:

I feel very comfortable talking to [the therapist] about things like that so...things that are quite emotive as well. I would definitely shy away from speaking to people about because you naturally avoid it if you know it's going to make you feel bad and there's no real benefit. That's what I felt any way. There's no real benefit about talking to others about it, whereas there is here. (C5)

Theme 1.4: Portraying my beliefs as unchangeable

Some clients felt that their therapist unhelpfully talked about their core belief as if it was a fixed entity that could not be changed, which led clients to feel less hopeful about overcoming their difficulties. Clients described that although being helped to identify their assumptions and core beliefs was extremely beneficial in enabling them to better understand their reactions in situations, the way in which the therapist characterised the belief was crucial. In the excerpt of the therapy session below, the therapist asked C3 whether his belief that he is "inadequate" could explain his feeling low when he did not achieve his goals:

C: You get a huge low if you don't do so well and you get like a huge high if you do reach that goal.
T: Right up and down
C: Yeah
***T: I suppose that what we've drawn out here, this belief that you are inadequate, is that linked to that (feeling low) at all?**
C: Pause...yeah when you feel low...yeah I guess so
T: And if you don't reach the maximum best then you're pushed into that (the worst) pile?
C: Yeah...it's true it's true.

Although C3 felt that his therapist's response made sense, the fixed, definitive way in which his therapist phrased the belief led C3 to feel worse.

Erm...when she used the word inadequate it probably made me feel erm...what's the word...quite down really. Just probably like...that just reinforces the black and white thinking. You're either the best or not, so emotions are quite discrete

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rather than continuous. So when she uses the word inadequate it makes me feel low (C3).

He went on to say that the statement "I am inadequate" did not fit with his experience all the time, and framing it as a discrete entity led him to feel firstly that his therapist did not understand him, and secondly that there was not much hope of this belief being changed.

CR Cluster 2: Identifying and labelling cognitive biases

The CR techniques included in this cluster were those that aimed at identifying clients' cognitive biases. This cluster is linked to, but distinct from, cluster one because it involved the therapist identifying and labelling clients' information processing biases, which are the processes that inform the content of clients' core beliefs and negative automatic thoughts (Westbrook et al., 2011).

Theme 2.1: Pointing out my thinking habits

Therapist responses in this category included the therapist explaining the concept of information processing biases and offering illustrative examples of these, i.e. describing the most common biases, and helping the client to consider these in relation to their own automatic thoughts.

Client accounts of the impact of this were very positive. In the majority of instances, therapists themselves selected which of the cognitive biases they felt to represent their client's thinking, and then discussed these with the client. Clients explained that their therapist being able to select the biases that resonated with them, led them to feel "reassured" (C7) and to have confidence in the therapist's ability to help them work through these biases. In the excerpt of the therapy session below, the therapist was explaining the concept of information processing biases, and helping C7 to consider these in relation to his own automatic thoughts:

> **T: What we tend to do in terms of our thinking is that we get into different habits of thinking or different patterns or habits. And you get**

different patterns that become more typical for different people. So one of them, for example that is very common is one that I like calling catastrophising
C: Mmm
T: So basically thinking of the worst case scenario
C: yeah it's like...I know it from experience (laughs)
T: And very often we have these thinking patterns and we don't really question them. We just take them for granted and because they're habits it's almost as if they happen automatically. So you get the catastrophising and I mean we haven't really spoken about social anxiety today very much, but what happens a lot in social anxiety is one called mind-reading
C: Mmhmm
T: So basically where you think you know what the other person is thinking about you.
C: Yeah. I always try to...when there's a girl I like...I always try to read her mind.

In the TAR interview, C7 described feeling understood and reassured when the therapist identified (in the sequence of responses above) the cognitive biases that fit best with his thinking. He also spoke about the importance of his therapist having an open manner, as opposed to "insisting" (C7) or delivering what he said as a statement of fact or pronouncement:

> *It's like he understands me well and this path that we are going on. He almost predicted it. I mean..he wasn't insisting on anything..that was me talking and him picking something out of it, but it was really reassuring that he is that much aware of the different blocks of my mind and how they interact with each other. So this was pretty reassuring, and yeah, I'm really lucky to be his client. (C7)*

The therapist of another client (C10) approached this exercise differently. He presented the client with a list of cognitive biases with their associated descriptions, and helped her to go through a process of selecting the biases that fit best. C10 reported finding this unhelpful. She described struggling to "figure out" what her patterns were, and said that she wasn't "paying much attention to the descriptions". She said that she would have preferred for her therapist to "just tell [her]" which fit best. It is important to note that the client said at this point in the session that she was

preoccupied with an upcoming meeting with a supervisor, and was struggling to engage with the session in general.

Theme 2.2: Providing a label

Clients particularly valued being given a label for their characteristic pattern of thinking. Having a precise descriptor for something which initially felt incomprehensible and inexplicable led clients to feel hopeful about managing their thinking.

This is exemplified in the following extract from C5's therapy session. C5 was describing a situation in which he had been highly anxious whilst waiting for the winner of a competition to be announced, hoping that his name would not be called:

> **C: Obviously I can't say for sure but had my name been called at that point I felt like I would have hit the ground running.**
> **T: Really?**
> **C: Yeah and then when it wasn't then a huge sense of relief came over me.**
> **T: Yep yep**
> ***T: So it sounds like there was a real catastrophizing going on**
> **C: Yes yes**
> **T: And if you tell yourself quite clearly that this is going to happen then you do start to feel quite unsteady.**

C5 found the therapist's use of the term "catastrophizing" gave his thinking a "realness" and concreteness to it, which instantly made it feel more manageable:

> *She was sort of clarifying things, and assigning 'catastrophizing' and I know what that is so yeah at this point it was definitely a relief more than anything. Um I personally find it quite helpful because it almost makes the problem a little bit more real in terms of being able to deal with it, because you can assign a label to it and be like, this is what I'm doing (C5).*

A minority of clients reported that having the therapist label their thinking in this way with the use of terms such as "black and white" and "all or nothing", seemed a little abrupt and "forceful" (C4). However, these clients explained that they were still able to draw benefit from the intervention because they trusted their

therapist and believed her/him to be well-intentioned. As C4 put it: "it's her way of "mak[ing] it clear to me that, that this is possibly, a vicious cycle, a damaging thing to me, something that should be worked on."

CR technique cluster 3: Disputing maladaptive cognitions

This cluster encompassed techniques aimed at challenging clients' unhelpful thoughts and schemas, including identifying evidence for and against a thought, the "continuum method" for changing core beliefs (Padesky, 1994), "Theory A Theory B" (Clark et al., 1998) and the behavioural experiment.

Theme 3.1: Challenging before understanding

This theme was characterised by clients feeling that the therapist moved too quickly to challenging them, before having fully listened to and understood their thoughts and feelings. As a result, clients perceived therapist's suggestions and attempts to challenge their thinking as unhelpful and "too simplistic" (C4).

In the example below, the therapist was eliciting the thoughts that C10 was having whilst trying to do a mindfulness exercise the night before a piece of coursework was due:

> **C: I did work till late on Saturday, but I was disappointed in myself. I thought I could have done more so on Saturday when I was doing it I felt like I was wasting time.**
> **T: Yeah.**
> **C: And that stopped me from doing the whole thing.**
> **T: So you were having the thought "I'm wasting my time"?**
> **C: Yep**
> **T: And that thought made it difficult for you to focus on your breathing**
> **C: Yeah**
> ***T: Yeah. And it's interesting because you seem to experience these erm very strong absolute thoughts, like I'm wasting my time, or like I'm stuck now and nothing can help me.**
> **C: Yeah**
> ***T: Erm...and what is interesting is that you then seem to take those thoughts very seriously. So you believe those thoughts**
> **C:Yeah**

In the TAR interview, C10 reported being aware that the therapist was beginning to try and "change [her] thinking", which she had felt had actually been relatively valid given the situation. She described feeling frustrated that her therapist did not fully understand how bad the situation was:

> C:But the way that I'm thinking is right and any other way is...bullshit
> R: What do you mean?
> C: Like...I had a coursework due, my sessions started till...I had coursework that's worth 90% of my mark. I mean like...yeah of course my thoughts are absolute

Theme 3.2: Allowing me to discover for myself

This theme was characterised by clients feeling that the therapist was actively directing them with challenging questions, but at the same time providing the space to reflect on what was being asked and to make discoveries for themselves, as opposed to the therapist imposing an alternative way of thinking on the client. A common reflection in clients' accounts was the importance of not being "hurried" or under pressure to simply "go along" with the therapist's line of argument.

This is exemplified in C5's reflections on the excerpt below. The excerpt is a snapshot of an interaction in which the therapist set about challenging C5's thought that his peers were negatively analyzing him in a group teaching session.

> **C: I felt like basically that they're analyzing me negatively, so they're saying what I'm thinking is stupid.**
> **T: Ok. So do you think you could come up with an alternative one [thought] for that? 'cause that's quite negative isn't it? that they're analyzing you negatively. I mean...what are they doing do you think whilst your talking?**
> **C: Well...I think they're (pause)**
> **T: They're listening?**
> **C: Well yeah**
> **T: Do you think they're thinking about what they're going to have for lunch**
> **C: Erm (both laugh) I mean probably listening. Some might be thinking about what they're having for lunch.**
> **T: Ok so they are listening to you, but do you know what they're thinking about what you're saying?**
> **C: No..no**

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T: So?
C: So...they could be thinking about something else to do with what I've said or what they've learnt.
T: Yep..yep
C: Could be a positive thing.
T: Yep we just don't know.
C: So you could put as an alternative thought...they're probably listening but I don't know what they're thinking.

In the TAR interview, C5 described that this sequence of therapist responses helped him to re-consider his original thought in light of the "evidence", and discover for himself that his thoughts did not reflect reality.

> *Well I think she's trying to make me work out myself why there are large holes in the argument, in the thought I'm having when I'm talking and I think everybody is analysing me. She's making me think about that situation and what I thought at the time, and I thought...what do I do when I'm listening to someone talk?.. what do I think when I'm listening to someone talk? And it's not really what I think others are thinking when I'm talking. I felt like she was allowing me time to work out and go through a process where I would realise why those thoughts are incorrect, or evidence to suggest why those thoughts are incorrect (C5)*

C5 went on to elaborate that it was the therapist's "open manner" that enabled him to feel "comfortable to take [his] time and just think about things". He also commented that it was important for him to feel that he "had the opportunity to say no, that's not what it's like, or no I disagree".

Other clients also commented on valuing the therapist's "tentative", "open" and "gentle" probing style, reporting that this enabled them to feel more open to having their thinking challenged, and gave them the sense that that they were "connect[ing] the dots" (C3) for themselves.

The importance of an open manner was demonstrated by two instances in which such a manner was felt not to be present. Two clients, both with the same therapist, reported that their therapist directed them towards "an answer that the therapist believed to be correct", in a manner that was firm, brusque and felt "quite impersonal" (C4). This was experienced as unhelpful. This is exemplified in the

following excerpt in which the therapist was encouraging C4 to evaluate his

tendency to check his breathing regularly:

> **C: So I look for that feeling and then when I find it, depending on how easy it is to get that shows me how easy the day's going to be in terms of breathing 'cause if it is hard to get early in the morning then I know that I'm going to have a horrible day.**
> ***T: What do you think about that whole process?**
> **C: It doesn't seem healthy but it seems like something I can't avoid. Maybe if I didn't think about it...it's like...when I used to smoke**
> **T: Mmhmm**
> **C: If you have a cigarette straight away you need to smoke like 15 a day**
> **T: Right**
> **C: But if you wait a couple of hours before you have a cigarette you'll smoke like 5 in a day**
> ***T: But...I...yeah it is that but I also...there's also a part of you telling yourself that if the breathing is bad now when I'm still in bed then it's definitely going to be a terrible day. Now I wonder, what do we think about that thought?**

C4 reported that although the question that the therapist asked ("what do you

think?") seemed to be an open question that appeared to be aimed at eliciting his

viewpoint, her tone of her voice led him to feel that she was "leading me towards the

answer that she believes is correct". C4 also felt that the therapist's utterances:

"mmm" and "yep", and the tone of the therapist's voice felt like "encouragement to

get to the point", and reminded him of a quote he had read somewhere: "nobody

listens to anyone; they're just waiting for their turn to speak".

C4 went on to say that although he understood his therapist's reasoning, the

impact of the therapist's approach was that it led him to feel that he "should answer"

in a certain way, whether or not he agreed with his therapist's point of view. This in

turn led him to try to defend his own perspective, and refute the therapist's:

> *"She [the therapist] is leading you know... she'll throw out an idea and it will be...I'll see the sense behind it completely, but possibly it's me because I'm being a bit stubborn erm...I'll be a bit resistant and she'll kind of keep on probing."(C4)*

These interactions were perceived to have an adversarial quality which led clients to invest their energies in defending their perspectives, as opposed to evaluating their thinking.

Theme 3.3: Helping me to analyse the implications of my beliefs

The responses included under this theme were characterised by the therapist asking questions that encouraged clients to think about the consequences of holding a particular belief. These questions were aimed at questioning the utility of the thoughts, and tended to be brought in by therapists once the validity of beliefs had been explored. When asked in an "open", "neutral" manner, these seemed to be particularly conducive to prompting thinking and evaluation on the part of the client. For one client, C3, this type of question led to an important shift in thinking which had not been achieved from evaluating the validity of his beliefs:

> **T: Ok so we're starting to think about it and it sounds like what you're saying is that you know this. This is kind of what your mind says, that you just have to be the best.**
> **C: Yeah I think as well a part of me is like...obviously other people's view might just be like...that's not a good way of thinking but I mean for me it feels like I should think that way.**
> **T: Yeah 'cause you've internalised this message, like we said, for so long**
> **C: Yeah**
> ***T: I suppose the question is...are there any downsides?**
> **C: Erm (pause) well yeah because you get these...you get like a huge low if you don't do so well.**

The client noted that this question had a more neutral quality to it (when compared with previous questions that felt "very leading" and critical at points), thus giving him an opportunity to genuinely reflect on his belief, as opposed to being focused on how the therapist viewed him, or on developing "common ground" to appease the therapist.

> *I think it's good. It manages to go a bit deeper into it I guess. Going back to example of the drugs. If your friend is like...what's the downside? then it feels like maybe they'd be up for it. I'm thinking in my head in terms of this thinking...yeah there probably is a downside I guess. It [the therapist's*

response]doesn't make me feel like I'm being criticised or being disagreed with. It's more neutral and so maybe you're not trying to cushion whatever you might say next. I think it's just reflection and evaluation on my own thinking...and maybe trying to convince myself rather than her (C3).

Theme 3.4: Disagreeing with my point of view

Clients picked up on verbal comments and particularly non-verbal cues (e.g. tone of voice) that signalled to them that the therapist disagreed with their point of view. This was uncomfortable for clients, and led one client to "downplay" his genuine thoughts, due to the fear of being criticised or judged.

For example, C3 and his therapist were exploring C3's "black and white thinking" around achievement, that there is only a "best" and "worst":

> **T: OK so if you were like here [in the middle] there might be some people better than you. Does that mean you can't make an impact?**
> **C: Hmm...it means you're making an impact but not the impact I see in my mind**
> **T: OK (pause) so is it the case that there's only this or this, best or worst?**
> **C: Yes I think so. I think it's that if you're just this [in the middle] then you might as well as just be like...you're just equal to the worst. There's no..**
> ***T: Oh ok!!! *(raised tone of voice)*. There's no middle ground?**
> **C: No. I either do well or do really bad.**
> **T: Ok so is the case that you either get the top first or fail. Is it like that?**
> **C: Yeah like...even if it was like 2.2 or like even though a 3rd is worst than a 2.2, I'd still class that as "worst"**

C3 felt that the therapist's "*high pitched voice*" signalled that she was surprised and had a different perspective. He went on to explain how this impacted on his response to the therapist:

> *I probably would have responded perhaps maybe in a better way if erm..she didn't raise her tone..coz obviously she raises her tone that signals to me that she disagrees, and maybe my next answer might be trying to normalise my views in her perspective (C3)*

Although the client reported that the therapist's sequence of responses in the above excerpt ultimately introduced a little flexibility in the his thinking by the end of the session, it also led him to become concerned with how the therapist viewed

him. The fear of being viewed negatively by his therapist and of being criticised by her, led C3 to focus more on "downplaying his view" to find some "common ground", and to try and "rectify" his therapist's view of him, as opposed to evaluating his belief:

> *I feel criticised definitely. I mean...going back to the drugs example with friends who raised their voice. They haven't said it but they've criticised your view, because clearly their view is opposing you...so if you did talk about it further they would criticise you......obviously a lot of people who have black and white thinking are going to have feelings of grandiose..if you attribute this thinking to somebody you didn't know for a long time, you'd probably assume that they're arrogant. So I'm thinking..what's she thinking? Does she think I'm like this? And I'm trying to say don't get the wrong picture I'm not....but that's how I think.(C3)*

In addition, the therapist's responses left him feeling concerned about what his thinking meant about him as a person, and whether he was "stuck with it":

> *I was thinking that maybe it wasn't normal...maybe my views were perhaps different to other people's....that things could be wrong...so I'm thinking....maybe I'll just always have that view even though it's not normal (C3)*

Despite all of this, however, C3 also said that "getting a feel for [the therapist's] views was not wholly negative, as it led him to feel that the relationship was more "human":

> *There's obviously like this relationship that's building between patient-therapist..I think raising the tone..and maybe it's this maybe it's that..it puts it more to a personal level. Obviously if the therapist was a computer...a computer is just saying...always agreeing with you..you're not really going to feel like ..a human relationship..and you don't want like a therapist who doesn't have like a human emotion to her...I think you need to be personal..coz to be fair you're going to interact with people not computers (C3).*

Broader aspects of the therapy: themes from the TAR

Two themes were identified that address broader aspects of clients'
experiences, i.e. those not linked to specific CR techniques. Clients spoke about
these spontaneously and emphatically in their TAR interviews.

"A human relationship"

All but one client commented on how having a trusting, supportive
relationship with their therapist was central to their experience of therapy, and even
more so, having a "human relationship" (C3), in which they could engage with their
therapist on "a personal level" (C6) was important in helping them to feel a sense of
"comfort" in the therapy (C6). Clients explained that the therapist engaging in small
talk, communicating empathy and showing their emotions from time to time
contributed to a relationship that more closely resembled a "natural relationship" that
they would have with somebody. Being able to develop this with their therapist was
highly affirming of clients' normality. Clients also emphasised the importance of
feeling that the therapist genuinely cared for them: "*I know that obviously you're not
friends and that's not what you want, but it shows that there is a level of care and
responsibility and that level of investment*" (C1).

Tailoring the therapy

Clients described engaging well with techniques when they felt that their
therapist had tailored their approach to their individual needs. For example, one
client spoke about feeling pleased when her therapist introduced a practical exercise
that was clearly not part of the therapist's original plan for the session, but was
relevant to an issue that was being discussed. She felt that it demonstrated that her
therapist was thinking about what would be most helpful for her:

I think I thought that she's very flexible in terms of...you know... I say she directs it, but she was looking for...even though it sounds like she's being disorganised going through files looking for paper, to me it shows she's being quite flexible, just following the path that I'm going down and thinking what's helpful for me (C9)

Another client spoke about how he was encouraged to contribute to the development of strategies and tools that could help him to manage his difficulties. He explained that this approach led him to feel that the therapist was not rigidly applying a set of techniques, i.e. "*like that's one technique and I explain it to you and now you do it, another technique, explain it, do it...it's not like that*" (C7). Instead, he felt that the therapist was open and responsive to his ideas and suggestions, which resulted in tools that were tailored to his needs.

Therapy in general encourages me to think about things that might potentially help me. I mean, not only the exercises that my therapist shows me, and tries to apply, but also the ones that I get my own conclusions from our interactions. So that's really good I think, because I might develop some extra techniques that will be personally beneficial for me. (C7)

Discussion

Overall, clients' accounts of their experiences of CR techniques were positive: clients reported developing greater insight into the factors maintaining their difficulties, becoming more adept at identifying their thinking habits and re-evaluating their initial perspectives. However, what was most striking from their accounts was that particular CR techniques could be experienced as helpful or unhelpful, depending on the way in which they were delivered.

With regards to identifying maladaptive cognitions, CR techniques were experienced as helpful when therapists were able to create a safe, empathic and trusting environment within which clients felt comfortable to confront difficult thoughts and feelings. Clients reported engaging less well when therapists asked

broad, non-specific questions to elicit cognitions, and when they framed beliefs as entities that were permanent and therefore unchangeable.

In relation to the identification of cognitive biases, clients preferred the therapist to take a directive role in pointing out their "thinking habits", and they described that being given something concrete, i.e. a label to represent the bias, brought about a sense of relief and inspired hope in clients.

Finally, clients experienced therapists' attempts to challenge their thinking as helpful when they felt that they were being helped to explore, discover and test out new ways of thinking, at their own pace, and without being weighed down by their therapist's pre-conceived views about the correct way to think. The therapist advancing to challenging the client, without having fully understood their concerns, was experienced as un-empathic and unhelpful, as was the therapist expressing disagreement with the client's own point of view. Interestingly, one client felt that the therapist expressing her point of view was a positive thing, because it gave the relationship a sense of realness to it.

Clients' accounts consistently indicated that the therapeutic relationship was crucial in enabling them to have trust in the therapist, be open to the process of therapy, and follow through with therapeutic tasks. In particular, clients highlighted the importance of the therapist being able to provide an empathic, warm and secure environment in the therapy. The therapeutic relationship has been identified as key to all types of psychological helping (Gilbert & Leahy, 2007; Duncan, Miller, Wampold & Hubble, 2010), but traditionally has received little attention within CBT. However, it is increasingly being recognised as of crucial importance (Gilbert & Leahy, 2007; Hardy, Cahill & Barkham, 2007). A comprehensive review of the impact of relational factors on outcome in CBT concluded that relational factors,

such as empathy and positive regard, have a consistent impact across client groups (Keijsers, Schaap & Hoogduin, 2000).

Clients' accounts in the present study demonstrated that feeling understood, in particular, was key to their experience of CR techniques. Its importance was perhaps most notable in therapists' attempts to challenge clients' thinking. If therapists moved too quickly to challenging before understanding, they were felt to be unempathic, and this led clients to be less willing to consider an alternative point of view. Furthermore, clients who felt their point of view to be disregarded by the therapist felt judged and criticised, and their energies tended to be more focused on their therapists' perceptions of them, rather than on evaluating their cognitions. In line with this, most CBT therapist guides and manuals emphasise the importance of delivering CR techniques within the context of a good therapeutic alliance (Beck, 1978; Padesky, 1993) and with compassion and acceptance (Westbrook et al., 2011). Clients' accounts supported this assertion.

Clients also consistently indicated that they valued the therapist directing the therapeutic process, but that a high level of therapist directiveness was unhelpful. For instance, the unhelpful theme "asking broad, unspecific questions" was characterised by clients experiencing a lack of scaffolding in the task of accessing core beliefs, constructs that are notoriously more difficult to access than negative automatic thoughts (Westbrook et al., 2011). Clients who reported being given more guidance and prompts engaged better with the process. Indeed, the "downward arrow" technique in CBT, in which clients are asked a series of specific questions, is recognised clinically to be the most effective method of guiding clients from surface (automatic thoughts) to deeper cognitive structures (Burns, 1980; De-Oliveira, 2011).

In three of the "helpful" themes: "pointing out my thinking habits", "providing a label", and "allowing me to discover for myself", what seemed to distinguish instances when therapist directiveness was experienced as helpful, from instances when it was experienced as unhelpful, was the therapist adopting a tentative, gentle and exploratory manner, whereby statements were presented as hypotheses that clients could reject or accept. This is consistent with collaborative empiricism, proposed to be "the central therapeutic relationship element" in CBT (Kazantzis, 2013, p. 386) which involves the client and therapist working as a team to develop hypotheses, ask questions and engage in testing these out, through a process of guided discovery (Padesky, 1993; Westbrook et al., 2011). Central to this approach is an atmosphere of curiosity whereby the therapist is eager to learn about the way in which the client views the world. Therapists are warned that adopting an authoritative stance is likely to result in an adversarial atmosphere which inhibits exploration and learning (Padesky, 1993). The accounts of some clients in the current study suggest that this may result in clients engaging superficially in CR activities. Interestingly, however, therapists not showing tentativeness in their responses (e.g. in the theme "pointing out my thinking habits") did not necessarily have a negative impact, when it occurred in the context of a good therapeutic relationship. This again demonstrates that the impact of therapist responses depends on the context in which they are delivered.

Finally, clients' accounts consistently indicated the importance of a "human", "real" relationship with the therapist. Indeed, a finding that was somewhat surprising yet provides support for this assertion was one client (C4) who, in response an expression of disagreement by his therapist, described that he experienced his relationship with his therapist as having a more "human" quality as a result. Within

person-centred (Rogers, 1961) and experiential (Yalom, 2001) approaches the

therapist's authenticity and realness is said to have a profound impact on the client:

> It is expected that the relationship with the therapist is the meeting of two
>
> live, real human beings, with the therapist fully present to his client. This
>
> situation is at the furthest pole from the therapist as an expert, analyzing the
>
> patient as object. It is a living together in communication that breaks the
>
> isolation of the patient (Rogers, 1959, p. 197).

There is some empirical support for the positive impact of therapist congruence on

the therapeutic alliance and on client improvement (Barrett & Berman, 2001; Gelso

& Hayes, 1998); however, the evidence is mixed and some clients associate a

"natural" congruent style with a lack of professional competence (Maluccio, 1979).

For clients in this study, a human relationship with their therapist was one of the

most salient aspects of their experiences.

Limitations and research implications

The main limitation of the study concerns the generalisability of the findings.

The sample consisted of middle class, well-educated university students with mild to

moderate mental health difficulties (mostly low mood and anxiety). They were

functioning well enough to undertake academic study, therefore were probably

higher functioning on the whole than a community sample. All but one reported

having a positive experience of therapy. This suggests that the representativeness of

findings within the wider community and with those who experience more severe

mental health difficulties is questionable.

An important consideration relates to decision making around determining

what counts as a theme. The approach taken in this study was in line with Braun and

Clarke's (2006) guidance on thematic analysis. They suggest that whether or not

participants' accounts are deemed to be crucial enough to "count" as a theme does not necessarily dependent on the number of instances of the theme across a data set, but rather "whether it captures something important in relation to the overall research question" (Braun & Clarke, 2006, p. 10). Therefore, the approach taken in this study was to judge the suitability of a theme on the basis of the prominence it held in clients' accounts as opposed to its prevalence in the data. In view of the role of researcher judgment in determining the "keyness" of themes, performing credibility checks including discussions with colleagues, and maintaining consistency in the approach used were crucial (Braun & Clarke, 2006).

An additional limitation concerns the validity of clients' accounts of their experiences during the TAR interviews. Despite the value of the TAR procedure in providing access to clients' thoughts and feelings close to the moment of interaction, individuals' accounts of their experiences could have been compromised by a range of factors such as lack of expressive skills, social desirability and fabrication (Elliott, 1986). In addition, the time gap between the recorded session and the TAR interview, although minimal, could have resulted in forgetting or inaccurate recall. Indeed, there are issues around participants' abilities to accurately comment on their own experiences retrospectively (Barker, 1985) and it is possible that, to some extent, clients in this study constructed accounts of their experience retrospectively.

Furthermore, this study focused on examining clients' experiences of the therapist's verbal responses in therapy. However, in the TAR interviews, clients commonly made reference to the paralinguistic features of the communication (e.g. pitch, intensity, tempo, silence) and the contribution of non-verbal body language (e.g. gestures, facial expressions). Future research could investigate these aspects using video-recordings to provide a more fine-grained understanding of the

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therapeutic process. The TAR procedure could also be used in future research to examine therapists' experiences, e.g. their intentions in therapy or their reactions to what clients say, which, in conjunction with clients' accounts, could elucidate instances of miscommunication between client and therapist.

An additional limitation is that all of the TAR interviews took place after the third or fourth therapy session. The study intentionally focused on these sessions (the mid-point in therapy) as it was felt that they would be most likely to contain CR techniques. However, it is unknown whether therapist responses would be experienced differently during the assessment or ending stage of therapy.

Finally, future studies could examine how clients' experiences of therapeutic techniques have an impact on outcome in therapy. Clients' accounts in this study provided information about the immediate and short-term impact of therapist responses, but it would be interesting to examine whether clients have better longer-term outcomes depending on the way in which techniques are delivered. For example, it may be that clients' perceptions of there being a collaborative approach leads to quicker or more sustained improvement in symptoms; conversely, a non-collaborative approach may be associated with poorer outcomes.

Clinical implications

The findings have implications for the development of clinical guidelines in relation to how CBT practitioners conduct their work with clients, and for the design and delivery of training to enhance the process of therapy.

Firstly, the findings demonstrate that attention to the development and maintenance of the therapeutic relationship is essential. Secondly, they imply that it is not sufficient for practitioners to be taught to become skilled in the technical aspects of therapeutic activities; it is crucial that they be encouraged and helped to

develop the relevant micro-skills and attitudes of openness, collaboration and respect in order to maximise the potential of the therapeutic process. Indeed, in a recent report from a task force of the American Psychological Association (APA) which aimed to identify effective therapeutic relationship elements and processes, one of the recommendations was that " . . . practice and treatment guidelines should address therapist qualities and behaviours that promote the therapy relationship" (Norcross & Wampold, 2011, p. 98) and that the relationship should act "in concert with treatment methods, patient characteristics, and practitioner qualities in determining effectiveness" (Norcross & Wampold, 2011, p. 98).

Finally, the TAR is a potentially useful clinical tool. It could be incorporated into clinical training to facilitate the development of the micro-skills of therapy, and into clinical supervision (Kagan, 1978; Kagan & Kagan, 1997) to increase therapists' awareness of the micro-processes of the therapeutic encounter, and to reflect on the therapeutic process in supervision. The TAR procedure might also benefit therapists and clients clinically and could be evaluated as an intervention. For instance, using this procedure to facilitate reflection on challenging events/ interactions in therapy, for example a disagreement or misunderstanding, with particular attention to the intentions and impacts of particular responses, might strengthen the therapeutic alliance and reduce the likelihood of therapeutic impasses. However, given what is known about client deference, the TAR procedure would need to be introduced in an open and collaborative manner to enable the client to genuinely reflect and share their perspective with the therapist.

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Part 3: Critical Appraisal

Critical appraisal

This critical appraisal contains my reflections on the process of planning and executing the literature review and the research reported in parts 1 and 2 of the thesis. It begins by providing an overview of the background to the research, including the process of deciding on the choice of methodology. It then focuses on three main areas concerning the process of conducting the research: the challenges of synthesising and appraising qualitative studies for the literature review, reflections on the Tape-Assisted Recall (TAR) procedure and researcher reflexivity.

Background to the research

The opening paragraph of Mick Cooper's (2008) book "Essential Research Findings: The Facts are Friendly" speaks to my dilemma at the beginning of the research endeavour. Cooper (2008) says:

> Research findings can be like many things. They can be like dusty old library books hidden away, decomposing and seemingly irrelevant to everyday life. Or they can be like a mallet: something we get hit over the head with by people who want us to think like them (p.1).

I was certain that I wanted my research project to be neither of these; instead, I wanted to produce a piece of clinically relevant research, that would be a source of information for, and that would be accessible and of benefit to, the practicing clinician. Moreover, I wanted to ensure as much as possible that it would privilege participants' views and experiences over my own.

Having just come to the end of my year-long adult mental health placement, where I had been delivering individual CBT with adults with severe and enduring mental health difficulties, my mind was brimming with reflections and curiosities about the therapeutic encounter, particularly about what enables it go well and why it

often does not go to plan or proceed as well as the treatment manuals imply that it should. I was aware of the research on client deference (Rennie, 1994), and my own experiences of clients tending only to feed back the positive aspects of their experience, and I wondered what clients would say if they felt able to give honest feedback about their experiences.

At this point I approached my supervisors, whose research interests were in examining communication in helping relationships, both formal (i.e. psychological therapy and GP consultations), and informal (i.e. social support and partner support), to discuss whether my wish to gain an understanding of clients' views could be shaped into a formal research project. I discovered that they had conducted research on client experiences using the innovative methodology Tape-Assisted Recall (Elliott, 1986; Kagan, 1980), which had enabled them to elicit not only clients' retrospective accounts experiences of the therapy as a whole, but clients' moment-to-moment experiences that occurred during therapy. This methodological approach appealed greatly to me as I felt that it had the potential to provide highly relevant information for clinicians about the minutiae of what they were doing in their practice. A literature search revealed a growing body of knowledge using this methodology to examine clients' and therapists' experiences of actual communication in therapy, but no research examining CBT in this way. This surprised me, given the vast body of research devoted to demonstrating its efficacy. I felt that conducting a study examining clients' experiences of CBT using this methodology had the potential to provide clinicians with specific guidance on what they could do to differently to improve their practice.

Challenges of conducting the meta-synthesis

The literature review presented in Part 1 of the thesis used the method of meta-synthesis to synthesise qualitative studies examining clients' experiences of CBT. There were a number of challenges encountered during this.

Firstly, synthesising qualitative research studies is an inherently contentious endeavour. Some researchers argue that in bringing together qualitative studies, qualitative findings are immediately de-contextualised, which undermines the integrity of individual studies and the whole purpose of qualitative research (see Sandelowski & Barroso, 2007). As Sandelowski Docherty and Emden (1997) say:

> To summarize qualitative findings is to destroy the integrity of the individual projects on which such summaries are based, to thin out the desired thickness of particulars…and ultimately to lose the vitality, viscerality and vicarism of the human experiences represented in the original studies (p. 366)

Most researchers would agree, however, that qualitative meta-synthesis offers a promising way of building up a cumulative knowledge base that can be usefully drawn upon in clinical practice (Pope, Mays & Popay, 2007), and be used to inform policy (Davies, 1999; Newman Thompson & Roberts, 2006; Silverman 1997). Although there is greater recognition of the value of synthesising qualitative research, methods for undertaking meta-syntheses have been described by researchers as "somewhat elusive with regards to [their] steps and procedures" (Paterson, Dubouloz, Chevrier Ashe, King & Moldoveanu, 2009). This means that to some extent, researchers must determine the best procedures for their particular needs. I found that the two most challenging aspects of conducting the meta-synthesis were (1) "finding the findings", i.e. deciding what constituted the primary

data for the meta-synthesis and (2) the critical appraisal of individual qualitative studies. These are considered in turn below.

"Finding the findings"

Extracting the findings from individual studies, or "finding the findings" (Sandelowski & Barroso, 2002, p. 213) is an issue that has been raised by other researchers conducting meta-syntheses (Sandelowski & Barroso, 2002; Thomas & Harden, 2007). Unlike the process of conducting qualitative analysis for individual studies, the primary data of a meta-synthesis are not the raw data, i.e. the interview transcripts of participants; rather, they are the authors' interpretations and organisations of the raw data (Thomas & Harden, 2007). Given that qualitative research is subjective, and reflects a plurality of approaches, encompassing a wide range of epistemological stances (e.g. realist and interpretive), qualitative researchers employ a variety of approaches in analysing data and reporting findings (Smith, 2008). Such diversity, however, complicates the process of extracting and bringing together findings for a meta-synthesis (Sandelowski & Barroso, 2002).

In the present meta-synthesis, the way in which the findings were reported varied considerably across the studies. Studies that employed a more descriptive approach to data analysis comprised lengthy descriptions of participants' experiences and numerous quotations, with little interpretation of the data. Conversely, those studies that employed a more interpretive approach to data analysis tended to consist primarily of the author's interpretations of the data, and provided little raw data (i.e. participants' quotations) to support the researchers' interpretations. This made it difficult to compare and combine findings from individual studies.

An additional challenge concerned the varied quality of analysis across studies. In a minority of studies, there appeared to be discrepancies between

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participants' quotations given in the appendices, and the researchers' interpretations of these. In one study it was questionable as to whether the researcher's descriptions or theme labels captured the essence of participants' quotations. These issues made it difficult to know how to assess the findings in some studies, specifically whether to give greater weight to the authors' interpretations or participants' quotations, and complicated the process of integrating these with other studies.

In the end, I decided to adopt the approach taken by Thomas and Harden (2007), which was to take all of the text underneath the "results" or "findings" headings in the studies as findings, including participant quotations and the authors' interpretations of these.

Appraising the quality of studies

There is considerable debate as to how the methodological quality of qualitative studies should be assessed, and whether it is even meaningful to assess quality within a qualitative approach (Murphy Dingwall, Greatbatch, Parker & Watson 1998). This discussion is part of a wider debate about different epistemological positions within the field of qualitative research regarding what is of interest, and therefore what constitutes "quality" (Dixon- Woods, Shaw, Agarwal & Smith, 2004). For instance, quality markers such as reproducibility and validity that are considered to be important within a realist paradigm are less meaningful in a relativist/ interpretive paradigm, where subjectivity, flexibility and reflexivity are prioritised (Willig, 2013).

In view of this lack of consensus, guidance was sought from the Cochrane Qualitative Research Methods Group (CQRMG; Hannes, 2011) and from several published meta-syntheses (Dixon-Woods et al., 2004; Malpass et al., 2009) to decide upon the most appropriate method of quality appraisal for this review. This was not

straightforward, however, as each of these sources suggested different methods of appraisal. Believing that the use of a structured appraisal tool (e.g. a checklist) would be the most rigorous way of assessing the quality of the studies, I initially elected to use the Critical Appraisal Skills Programme (CASP, 2002) checklist, recommended by the CGRMG (Hannes, 2011), which includes a numerical scoring system. The intention was to exclude the papers that scored the lowest, i.e. did not satisfy the CASP criteria (Feder, Hutson, Ramsay, & Taket, 2006). However, some papers failed to meet all of the criteria, and it became evident that this approach was going to result in the exclusion of papers that could provide valuable insights into clients' experiences. Dixon-Woods et al. (2004) consider that:

> A study may be judged to have followed the appropriate procedures for a particular approach, to give information on selection of participants, and to provide clear details of the method followed. Yet the study may suffer from poor interpretation and offer little insight into the phenomenon at hand. On the other hand, a second study may be flawed in terms of the transparency of methodological procedures and yet offer a compelling, vivid and insightful narrative, grounded in the data. (p. 224).

I turned to the literature to search for an alternative method of appraisal that would take into account both methodological quality and conceptual relevance in the process of appraisal, but what I discovered was that there was no one set of guidelines or criteria that could be considered definitive, and it seemed that perhaps even more important for appraising quality than the specific guidelines used, was having an understanding and appreciation for qualitative principles and the methodological implications of the studies being appraised (Barbour, 2001; Kuper, 2008).

In view of this, I decided to use an iterative approach that enabled me to draw on my understanding of the core elements of qualitative research: credibility, transferability, dependability and confirmability (Hannes, 2011). However I also felt that using a set of guidelines (the CASP 10 questions for appraising qualitative research) flexibly, would be helpful in drawing my attention to relevant aspects that I may not have otherwise considered.

The challenges of the Tape-Assisted Recall (TAR) Procedure

The process of carrying out the TAR interviews demonstrated to me what a powerful methodology TAR could be in providing access to participants' thoughts and feelings as close to the moment of interaction as possible. However, whilst the majority of participants were able to manage the admittedly quite unusual task of focusing on their experiences of the therapeutic processes, some participants found this difficult and tended to concentrate more on the content of the therapy session, i.e. the actual difficulty being discussed, particularly when it was emotive for them. Furthermore, it often seemed quite difficult, at least initially, for participants to take a meta-position whilst listening to the recording, i.e. separating the thoughts and feelings they were having whilst listening to the recording from those that occurred at the time of the session.

I discovered that many participants could learn to focus on the process and take a meta-position with gentle and respectful questioning. When I noticed that participants were focusing exclusively on content, I would empathically reflect the content and then re-direct them to a focus on what the therapist was doing in the excerpt, e.g. by asking "I wonder what your therapist was trying to do in saying that?" When the content elicited strong affect from the participant, I often allowed them to explore the concern briefly and then brought them back to the focus on

process by saying something like "so taking a step back from that...". This was often successful in bringing participants back to a focus on process, whilst ensuring that they did not feel dismissed or that their emotions had been invalidated.

An additional challenge was to manage the dual role of being a psychologist in training and a researcher. During the process of conducting the interviews, I realised that the way I was responding to participants' concerns (empathic validation, active listening and supportive comments) was at times inadvertently encouraging clients to talk further about their concern. Sometimes I felt that I allowed clients too much space to talk about their concerns and I also noticed my own tendency to want to gently challenge assumptions that I believed to be contributing to their distress. Larsen, Flesaker and Foundation (2008) reflect on experiencing a similar dilemma in their TAR research. They provide some helpful suggestions for how to manage the dual clinician-researcher role. These include constantly reminding oneself of one's role and of the purpose of the meeting, and on encountering difficult material with a participant to say to oneself "It's okay to let that go. That's not my role right now" (Larsen et al., 2008). At the same time Larsen et al. (2008) reflect on the importance of creating a safety plan with the participant to discuss who he/she might be able to talk with about the difficult feelings evoked once the research interview had come to an end. I feel that reminding myself of these suggestions before every TAR interview enabled me to manage the dual clinician- researcher role more effectively.

On reflection, I think that being a clinical psychologist in training was greatly facilitative in the interviews with participants. The skills I have acquired during training helped me to be able to develop rapport with participants within a relatively short space of time; to facilitate disclosure (e.g. using advanced listening skills and non-leading questions); and generally to conduct interviews in a way that elicited

rich and elaborate material. These skills were in part a function of my training and were invaluable in the process of conducting the TAR interviews.

Researcher reflexivity

Researcher reflexivity in qualitative research entails us as researchers to acknowledge the influence of our prior experiences, assumptions and biases on the construction of meaning during the research process (Gough & Madill, 2012; Willig, 2013). This is based on the premise that, in qualitative research, "knowledge cannot be separated from the knower' (Steedman, 1991, p. 53), and that it is impossible to remain "outside of" the subject matter (Willig, 2013). Willig distinguishes between epistemological reflexivity and personal reflexivity. These will be considered in turn.

Epistemological reflexivity

Epistemological reflexivity involves reflecting on the way in which our assumptions about the world and about knowledge have influenced the decisions made during the research process (Willig, 2013). Broadly speaking, this study adopted a phenomenological approach, which is concerned with studying the "lived experience" of participants and their perceived meanings, as opposed to capturing an objective truth or reality (Smith, Flowers & Larkin, 2009). Typically within phenomenological research, research questions are not usually pre-determined, and if they are, they are kept as open as possible. In addition, researchers within this approach are not dictated to by their interview schedules, instead they are guided by them (Smith & Osborn, 2003). They follow the client's lead throughout, and remain open to what may appear (Ray, 1994).

In the present research, although I was concerned with understanding participants' experiences (in line with phenomenology), the focus of my research was on examining their perceptions of a specific aspect of their experience, i.e.

cognitive restructuring. This decision was made on the basis of having identified a gap in the existing literature, as opposed to being guided by what clients found most salient. In doing this, I made an assumption that this aspect of therapy was significant for clients, and could reveal something important about their experiences of CBT. There was a tension in the research between sticking to this agenda (which is not strictly consistent with a phenomenological approach), and following the client's lead. Interestingly, in the latter case, I discovered that clients tended to speak more about aspects of the therapy not related to the techniques, namely the therapeutic relationship and the way in which the therapist tailored interventions. Although I attempted to represent this in the report of the findings, it is likely that my research question and subsequent interview schedule limited what could be found with regard to these aspects.

Furthermore, guided by a phenomenological approach to research, I was aware of the need to engage in the process of "bracketing" (Gibbs, 2007), defined as "becoming aware of one's implicit assumptions and predispositions and setting them aside to avoid them unduly influencing the research" (Morrow, 2005). The idea is that by bracketing, one is able to get at the "pure" phenomenon from the participants point of view. Bracketing is something I endeavoured to do during the research (see personal reflexivity below); however I found it difficult to do in practice. I also had questions about whether the notion of bracketing, which would render the researcher objective or detached from experience, fit with an approach that acknowledges and prizes involvement in lived experience (Finlay, 2008). This is a challenge that is described by many qualitative researchers; The most well-known conception of bracketing suggests that the researcher engages in a somewhat mechanical process of putting aside their biases (Finlay, 2008), and there is discussion amongst qualitative

researchers about the extent to which this is humanly possible given the theory-dependence of observation (Barker, Pistrang & Elliott, 2002), and also regarding whether it is the best characterisation of the process of bracketing.

Instead, some researchers suggest that taking a phenomenological stance is about engaging in a phenomenological attitude of a willingness or "preparedness to be open to whatever may emerge rather than prejudging or pre-structuring one's findings" (Finlay, 2008). However, rather than simply being a process that involves suspending one's judgment, it is an attitude in which the researcher adopts "a sustained and focused stance" (Finlay, 2008).

This conceptualisation fit better for me and brought forth ideas of what I could do to hold a phenomenological attitude as opposed to what I must do remove my assumptions (which I felt was impossible to do completely). Specifically, I endeavoured to delve into participants' meanings (Morrow, 2005) by using open questions, taking a non-knowing stance, not assuming individuals' meanings, and remaining curious about participants' experiences and realities. I also made attempts to catch myself thinking that I already "knew" what the participant was going to say when I thought I had encountered this before, and in these instances would try to approach the participant's account with "fresh eyes" (Finlay, 2008). I feel that attempting to cultivate this attitude reduced the influence of my biases and assumptions on the research process.

Personal reflexivity

Personal reflexivity involves reflecting on the way in which our experiences, values and expectations have shaped the research, and how the research has affected and changed us personally, and as a researcher (Willig, 2013).

As stated in my empirical paper, in addition to my CBT leanings, I have a particular affinity with person-centred approaches because I feel that they are underpinned by values and principles that resonate with my own spiritual beliefs and my preferred world-view (e.g. belief in the individual's natural self-healing process, the centrality of genuineness, warmth, acceptance, and non-judgmentalism). This would inevitably have influenced what I was most drawn towards in clients' accounts, and possibly what I privileged and asked more follow-up questions about.

However, having identified this as a bias early on in the research process, I tried to ensure as much as possible that I stayed as close to participants' accounts as possible, by adopting the phenomenological attitude described above. In fact, I wonder whether it was my commitment to person-centred values and wish to hear and give prime importance to the client's voice that assisted me most in this process.

In addition, my background in CBT meant that I had expectations and beliefs about what participants might experience as helpful and unhelpful. In fact, some of the prompts I used, in conjunction with the theoretically-driven questions in the interview schedule (e.g. questions about whether they felt criticised, motivated, and hopeful), were based on my assumptions and experiences of delivering CBT. Again, however, I tried as far as possible to be led by the client and to use these only to clarify what the client was trying to say. In the analysis stage, an important part of the process was to gain participants' feedback on a summary of the main ideas expressed in their interview. This enabled me to check whether my interpretations were reflective of clients' views, as opposed to my own assumptions.

Regarding the second aspect of personal reflexivity, i.e how the research changed me, I learned about the immense potential that cognitive restructuring techniques have to bring about change in clients thinking (and hence their lives),

which is achievable through utilising the relational context of therapy. I had always believed that the therapeutic relationship plays an important role in therapy, but I was struck by how much it was endorsed by clients in this study. In particular, the notion of "a human relationship" left me thinking about what might get in the way of establishing such a relationship with clients in my own practice. Although it is difficult to acknowledge, I wonder whether the tendency I have, and believe we as a profession have, to create a distinction between "the healers" and "the afflicted" (Yalom, 2003, p. 8) prevents us from being able to be genuine and "human" with clients. This is something I have reflected on before, but discovering that this was so central to clients' experiences has refreshed my commitment to reflecting on how I can implement this in my day to day therapeutic encounters.

One of the findings that surprised me most was that clients experienced a moderate amount of therapist directiveness as helpful. This was contrary to my assumption that non-directiveness was most enabling and empowering for clients. Learning this has led me to be less wary about being directive in sessions, provided that I also remain tentative and open to feedback from clients.

Finally, the process of conducting the TAR interviews was extremely thought-provoking for me. Having the opportunity to be privy to clients' inner thoughts and feelings about the helpfulness of therapy tasks (which were not often disclosed in the therapy) has demonstrated to me the importance of creating an open dialogue in therapy, whereby clients feel able to provide honest feedback about their experiences. I also realised that taking an outsider position immediately puts you in a different, more reflective position in relation to the material being listened to, and I often found myself thinking how valuable it would be for therapists to be given the opportunity to occupy this position. Further, clients' reports of finding listening back

to their sessions helpful in refreshing their memory and consolidating learning led me to consider using therapy recordings as an adjunct to therapy, i.e. to give to patients to listen to between sessions.

In conclusion, as Cooper (2008) puts it, research findings needn't be like "dusty old library books" or a "mallet" that we get hit over the head with (p.1). Rather, they can be like "good friends: something that can encourage, advise, stimulate and help us" (p. 1). Hopefully the findings of the current study can be put to this end and be of use to researchers, therapists and clients.

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Appendices

Appendix A: Letter of ethical approval

UCL RESEARCH ETHICS COMMITTEE
GRADUATE SCHOOL OFFICE

🏛 UCL
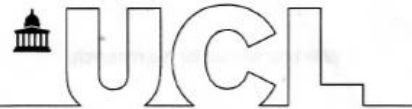
Professor Chris Barker
Department of Clinical, Educational and Health Psychology
UCL

22 January 2013

Dear Professor Barker

Notification of Ethical Approval
Project ID: 4326/001: How clients experience CBT techniques: a brief structured recall study

I am pleased to confirm that in my capacity as Chair of the UCL Research Ethics Committee I have approved your study for the duration of the project i.e. until January 2014.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events
For non-serious adverse events you will need to inform Helen Dougal, Ethics Committee Administrator (ethics@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events
The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes for the research.

Yours sincerely

Professor John Foreman
Chair of the UCL Research Ethics Committee

Cc: Darshan Mann

Appendix B: Overview of procedure and instructions for therapists

UCL

How clients experience CBT techniques: a brief structured recall study

Overview of procedure

Darshan Kaur Mann
ucltherapystudy@gmail.com

Thank you for agreeing to help with recruitment for the study. This is a double-sided A4 sheet that contains a step by step account of what will happen in the study and what you need to do.

Procedure for researcher and therapist

1. *Therapist asks client to participate in the study*
   a) Therapist gives out a flyer in session 1 to every new client that they are seeing for therapy
   b) Therapist allows time for client to consider (approx. one week)
   c) In the next session the therapist asks for the client's decision
   d) If the client agrees to participate, the therapist takes down name and contact details, and passes these on to the researcher via email

2. *Researcher contacts client to obtain verbal consent and arrange interview*
   a) Researcher calls the client to provide further details of study and sends the client the information sheet and consent form via email
   b) Researcher obtains verbal consent to record the next therapy session, and to interview the client
   c) During the same telephone conversation, the researcher arranges to interview the client within 48 hours of their forthcoming therapy session

3. *Therapist records session*
   a) Researcher reminds therapist (via text or email) half an hour prior to the session to record forthcoming therapy session

4. *Therapist sends recording to researcher*
   a) Researcher reminds therapist (via text or email) immediately after the session, to send recording via UCL drop box

5. *Researcher reminds client about the interview*
   a) Researcher sends a reminder text to client about the pre-arranged interview with researcher.

6. *Researcher conducts interview with client*

    a) Researcher obtains written consent and interviews client.

Procedure for therapist

1. *Ask your client to participate in the study*
   a) Pass on the study flyer to every new client that you start to see in session one of your therapy
   b) Give the client time to consider (approx. one week)
   c) In your next session ask for the client's decision
   d) If the client agrees to participate, take down name and contact details and pass these onto me via ucltherapystudy@gmail.com or telephone ▮▮▮▮▮▮▮▮

2. *Record therapy session*
   a) I will text/email you half an hour before your therapy session to remind you to record this.

3. *Send recording of session to Darshan*
   a) I will text/ email you immediately after your therapy session to remind you to send me the recording via UCL drop box

Thank you for helping out with the study!

Darshan Kaur Mann
Trainee Clinical Psychologist
ucltherapystudy@gmail.com
▮▮▮▮▮▮▮▮

Appendix C: Recruitment flyer

Are you in therapy or counselling?

Would you like to talk about your experience?

As part of my doctoral research in Clinical Psychology, I am interested in talking to UCL students about a recent therapy session, to explore their reactions to things the therapist says.

Your experiences may help us understand what therapists can do in order to increase the effectiveness of therapy.

People often value the opportunity provided in this type of study to reflect on their experience of being helped.

What will it involve?

- If you are interested in taking part, let your therapist know and they will forward your details on to me.

- I will then contact you to confirm your interest in participating and to answer any questions.

- Then I will arrange to record your next therapy session, and arrange to meet with you shortly afterwards to ask you some questions about it.

- You will be given a £10 gift voucher as a token of our thanks for your participation.

- **Data Protection Act 1998:** The personal information that you give for this survey will only be used for the purposes of the survey and will not be transferred to an organisation outside of UCL.

To find out more about the study, or to take part, please contact me.

Darshan Kaur Mann BScTrainee Clinical Psychologist
Department of Clinical Educational and Health Psychology, UCL

Telephone: ▉▉▉▉▉▉▉▉

Email: ucltherapystudy@gmail.com

Appendix D: Participant information sheet

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How clients experience CBT techniques

Information Sheet for Participants

We would like to invite you to take part in this research project. You should only take part if you want to. Before you decide whether you want to take part it is important for you to read the following information and discuss it with others if you wish. Please ask us if there is anything that is not clear, or if you would like more information.

What is the project about?

We are interested in clients' reactions to psychological therapy, in particular cognitive-behavioural therapy (CBT). Therapy often consists of different therapist techniques, some of which can feel helpful and others less so. This study aims to understand how certain therapist techniques are experienced by clients.

Who is being invited to take part?

We are inviting clients who are receiving individual CBT at UCL Student Psychological Services to participate.

Do I have to take part?

It is up to you to decide whether to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Even if you do decide to take part you are still free to withdraw at any time and can do so without giving a reason. Withdrawing from the study will not affect the therapy you receive.

What will I be asked to do?

If you decide to take part we will arrange with your therapist for one of your next therapy sessions to be audio-recorded. Soon after the session the researcher will contact you via telephone to arrange a time, ideally within 48 hours of the recorded therapy session, to meet with you. During this meeting, the researcher will listen with you to the recording of your therapy session and will ask you questions about various aspects of it, in particular what you found helpful or unhelpful. With your permission, the discussion will be recorded so that we have an accurate record of what was said. You will also be asked to complete a brief questionnaire. The whole meeting will last about an hour, and will take place at UCL.

A few weeks after the meeting, the researcher will send you a summary of what was discussed for you to comment on, in order for us to make sure that we have an accurate understanding of what you said.

What will happen to the information that is collected?

The recording of the discussion with the researcher will be transcribed (written up). We will then erase the recording. The transcription will be made anonymous; names and any identifying information will be removed so that you cannot be identified.

All written information will be stored securely and will be destroyed five years after the study has ended. All data will be collected and stored in accordance with the Data Protection Act 1998.

Everything that you tell us will be kept confidential; only the research team will have access to what has been said. The only time confidentiality would be broken is if we became concerned that you or another person were at risk of serious harm. If we did need to tell someone else then, where possible, we would discuss this with you first and it would be managed as sensitively as possible.

Once the project is over, the results will be written up as part of a doctoral thesis and may be submitted for publication in a professional journal. Reports will not reveal the identity of anyone who took part. A summary of the findings will be given to those who took part in the project.

Are there any risks of taking part?

There is a chance that the research might bring up feelings about personal issues raised in the therapy. If this were to happen, the researcher will be able to talk this through with you, and you will have the option of ending the discussion about your therapy session

What are the possible benefits of taking part?

Participants in previous similar studies have reported that they enjoyed and benefited from the process of talking about their experience of therapy in detail. We hope that the information we obtain from this study will advance knowledge about the principles of effective therapy, and improve practice to help other clients receiving therapy.

Further information and contact details:

If you have any questions about this study, please contact the researcher, Darshan Kaur Mann. Email: ucltherapystudy@gmail.com. Telephone: 020 7679 5962 (UCL ext. 45962)

Thank you for considering taking part in this study.

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 4326/001

Appendix E: Participant consent form

Informed Consent Form for Participants

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Project: **How clients experience CBT techniques: a brief structured recall study**

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 4326/001

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you.

If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Participant's Statement

I..

- have read the notes written above and the Information Sheet, and understand what the study involves.
- understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
- consent to the processing of my personal information for the purposes of this research study.
- understand that my participation will be audio recorded and I consent to use of this material as part of the project.
- understand that such information will be treated as confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- understand that the information I have submitted will be published as a report and I will be sent a summary on request. Confidentiality and anonymity will be maintained and it will not be possible to identify me from any publications.
- agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

Signed: Date:

Appendix F: Demographic questionnaire

Participant Identification Number:

Demographic questionnaire

Title of Project: How clients experience therapy
Researcher: Darshan Kaur Mann

1. What is your gender?

Male ☐   Female ☐

2. How old are you?

....

3. Which faculty are you studying at?

☐ Arts and Humanities
☐ Brain Sciences
☐ Built Environment
☐ Engineering Sciences
☐ Laws
☐ Life Sciences
☐ Mathematical and Physical Sciences
☐ Medical Sciences

4. What level are you studying at?

☐ Undergraduate
☐ Masters or Diploma
☐ PhD or other Doctorate

5. Please tick the box that describes your student status

☐ Home student
☐ European Union
☐ Non European Union

6. How would you describe your ethnic background?

☐ Asian or Asian British
☐ Black or Black British
☐ Chinese
☐ White or White British
☐ Mixed White
☐ Other Ethnic background........................

7. What problem brought you to therapy (briefly)?

....

....

8. How many times have you seen your therapist?

....

9. Have you ever seen a counsellor or therapist previously?

....

Appendix G: Protocol and interview schedule

How clients experience CBT techniques

Protocol and semi-structured interview for tape assisted recall (TAR)

Darshan Kaur Mann
ucltherapystudy@gmail.com
Updated: 6th March 2013

Aim
The primary aim of the TAR interview is to explore clients' reactions to specific CBT techniques.

Context
Before the interview, the researcher will listen to a recording of the client's therapy session and select 3 or 4 extracts that contain a cognitive behavioural intervention. The TAR will ideally take place about 2 days after the therapy session.

Equipment
- Digital recorder and play back device (laptop)
- Questionnaires (Demographic questionnaire; Working Alliance Inventory)
- Client protocol sheet
- Notepad and pen

Procedure

1. Questionnaires

Clients will be asked to fill out:

a. Demographic questionnaire

b. Working alliance inventory

2. Tape assisted recall

Explain the aim of the study and the procedure (this will also be on a printed sheet for the client to read along):

Aim:

"I am interested in finding out how certain techniques that are commonly used by therapists in therapy are experienced by clients.

I am researching this using a method called Tape Assisted Recall – or TAR for short. I will explain how it works. The instructions are also written down so you can follow along if you like.

We will listen to recordings of some parts of your therapy session together and then I will ask for some specific feedback from you about your reactions to these.

We will probably go into quite a bit of detail about your experiences. I will be particularly interested in what you thought and felt at these points during the session. There are no right or wrong answers; I am simply interested in your individual experience in the session."

Format:
"We'll begin by talking about the therapy session generally. Then we'll play some parts of the session and I'll ask some more detailed questions about it".

Co-researchers:
"This is a collaborative exercise. I want to enlist your help in trying to make sense of the sorts of conversations that therapists and clients have. I therefore hope that you will be able to talk as freely and openly about your reactions to the conversation. There are times when conversations in therapy don't go perfectly. My aim is not to criticise or point out faults in your therapist, but simply to understand better what might make things go well and not so well."

Confidentiality:
"I won't be telling your therapist anything that you say."

Discomfort:
Please tell me if anything is uncomfortable or upsetting during this process, or if there is anything that you don't understand. We don't expect there to be any problems, but if there are then please let me know. We can break or stop at any point."

Questions:
"Do you have any questions before we start, or anything that you are unclear about? You can stop me at any point during the interview if you have any questions."

3. General impressions of therapy session

Aim: to get an overall idea of the impact of the therapy session, prior to the TAR.

3.1 "Before we listen to the tape, did you have any general reactions to the

therapy session?

3.2 " Was there anything that stood out in anyway?"

3.3 "Overall, how helpful or unhelpful was the therapy session for you?

3.4 "If you were to rate 'helpfulness on a scale from 1 to 6 where 1 is very

unhelpful and 6 is very helpful, overall how helpful or unhelpful was it for you

to talk with your therapist (show scale)

3.5 "Is there anything from the conversation that sticks in your mind as being

particularly helpful?"

3.6 "…or particularly unhelpful?"

4. Tape-assisted recall interview

Extracts that are identified by the researcher as theoretically interesting (e.g. will be selected at regular time intervals (e.g. every 5-6 minutes).

"I am going to play back 3-4 extracts of your session one at a time, and I will ask you some questions after each extract. I'd like your views on these parts of the conversation. I just want to reiterate that there are no rights or wrongs here."

"I am now going to play back extract 1. Whilst we are listening to it, please bring to mind what it was like for you at this point in the therapy session. After I have played the extract, I will ask you some questions about some of your experiences during this part of the session, including your thoughts and feelings about what was said."

Play back tape extract 1. For each tape extract played ask the following questions (Questions for tape-assisted recall). Give a copy of these questions to the client so that they can follow along. Record the client's responses so that they can be transcribed later.

Questions for the tape-assisted recall

4.1 What was it like for you at that point in the session?

4.2 How did you feel after the therapist said that?

4.3 What, if anything, went through your mind?

4.4 How helpful or unhelpful was what your therapist said then? (description and ratings 1-6?)

4.5 What do you think your therapist was trying to do in saying that?

4.6 How would you have liked your therapist to respond to you at that point?

4.7 *Did that* (response) *have any impact on how you thought/ felt about/understood your problems?*

4.8…at the time?

4.9…later?

Theoretically driven questions depending on the technique used

4.10 Did that technique have any impact on how you thought/ felt about/ understood your problems?

4.11 …At the time?

4.12… later?

Follow the same procedure for remaining extracts

Appendix H: Working Alliance Inventory

(Removed due to copyright)

Appendix I: Key stages of the thematic analysis

Example of initial stages of analysis: Generating a list of all the features of the data related to Client 5's descriptions of the impact of a technique.

Technique: Identifying Evidence for and against (Cluster 2: disputing maladaptive cognitions)

Excerpt	*Initial list of features of the data*
R: what do you thinks kind of the kind of intention behind that question she's asking?	
C5: Um… (pause) well I (pause) I think um she's kind of she's trying to um make me work out myself um why there's sort of large holes in the not the argument but the thought that when I'm kind of when I'm talking and I think, this is sort of in a group teaching session, um why I then think everybody is analysing me and um yeah and so she's making me think about um that situation and I guess at the time I then thought what do I do when I'm listening to someone talk, what do I think when I'm listening to someone talk and it's never it's not really what I think when, what I think others are thinking when I'm talking, um so I think although I can't quite remember sort of the answers I felt like she was allowing me time to kind of work out and go through a process where I would realise that what's basically the whole, why I think it's, why those feelings are kind of incorrect, those thoughts are incorrect, or evidence to suggest why those thoughts are incorrect.	*trying to make me work out myself why there's sort of large holes in the not the argument* *she's making me think about what do I do when I'm listening to someone talk...it's never what I think when, what I think others are thinking when I'm talking* *allowing me time to kind of work out and go through a process where I would realise that those feelings are kind of incorrect*
R: Yeah so she, yeah, so you're saying this is kind of this is part of that process she's kind of allowing you to reflect on that. How is it that you feel, what is she doing that's um that makes it feel as if she's allowing you that space?	
C5: Um (pause) well I think um it was almost the way that she said was um it was just a very open question, it's just sort of but do you know really, or it was like what they're thinking I think um.. that and then then doesn't say anything else after and that instantly sort of makes me think about what, um what she's just said, um so I think it's just the way it's sort of the way its delivered, and yeah and again comes back to that I just feel quite comfortable to take my time and just think about things um so..	*the way that she said it* *it was a very open question* *I think it's just the way it's sort of the way its delivered, and yeah and again comes back to that I just feel quite comfortable to take my time and just think about things*

R: And what do you think enables you to feel comfortable in that moment?

C5: Yeah, yeah so um just feeling very comfortable and I guess because I've had four sessions with her now and I know that you know that the way she asks questions is like that so I kind of know that that's been a question that she's asked, and I know that I've got time to just think about it if I want to or just slowly just kind of work it out, or um yeah so...

the way she asks questions is like that

I've got time to just think about it if I want to or just slowly just kind of work it out

Further on in transcript:

C5: Everything she was saying I could totally see her point and I agreed with it um so I had kind of I didn't really have anything to add because I agreed but if I disagreed I think I could have happily said um and then she would have, and then it wouldn't have been a bad thing, I don't know, I felt like I had the opportunity to say no, that's not what it's like, or no I disagree, but I mean I agreed entirely so it was just me kind of nodding and just kind of realising um especially though the global point that she made its just its just so true that whenever um well I mean still when it happens whenever I'm talking or anything assuming that everybody's thinking exactly the same sort of like analytical negative things when obviously, and then I had never thought about this but then obviously that's not the case whatsoever. Um and just made it very much more realistic knowing that people are listening yes I mean that's the one thing that we do know, but you just can't tell what people are thinking so um you, why assume that everyone is thinking a negative thing

I could see her point and I agreed with it

if I disagreed I think I could have happily said and then it wouldn't have been a bad thing

I felt like I had the opportunity to say no, that's not what it's like, or no I disagree

just made it very much more realistic knowing that people are listening

Example of the second stage of analysis: tentative codes given to data

Initial list of features of the data

Tentative codes given

Trying to make me work out myself why there's sort of large holes in the not the argument

encouragement to/ making me work it out for myself

she's making me think about what do I do when I'm listening to someone talk...it's never what I think when, what I think others are thinking when I'm talking

Enabling reflection/ evaluation of thinking

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allowing me time to kind of work out and go through a process where I would realise that those feelings are kind of incorrect	*Time to work it out for myself*
the way that she said it	*Delivery crucial*
it was just a very open question	*Open question*
I think it's just the way it's sort of the way its delivered, and yeah and again comes back to that I just feel quite comfortable to take my time and just think about things	*Feeling comfortable to take my time*
the way she asks questions is like that	*Familiarity with style of questioning*
I've got time to just think about it if I want to or just slowly just kind of work it out	*Comfortable to work it out at my own pace*
I could see her point and I agreed with it. If I disagreed I think I could have happily said and then it wouldn't have been a bad thing. I felt like I had the opportunity to say no, that's not what it's like, or no I disagree	*Able to disagree/ hold a different point of view*
just made it very much more realistic knowing that people are listening	*Thinking becoming more realistic*

Example of a later stage of analysis: codes being compared across transcripts and being collated into tentative themes/ code labels across the set of interview transcripts

Tentative theme labels: providing encouragement to work it out for myself/ guiding discovery.

C5: Encouragement to work it out for myself.

Delivery of questions important- open manner

Feeling comfortable to go at my own pace

Able to disagree

Result: more realistic thinking

C2: Therapist "directing down a path with questioning", but feeling encouraged to "come to my own conclusions".

Her manner: "hesitant", "tentative". "Not a statement or judgment".

C3:   "Slow steering" towards a different perspective.

Resulted in feeling able to "connect the dots myself".

Examples of the converse- feeling under pressure to agree with the therapist's perspective:

C4:   "Leading me towards the right answer". "Pressure"/ being "hurried" to comply and "agree with the therapist's point of view", rather than working out for myself.

Values hearing the therapist's point of view however a brusque "forceful", "impersonal" manner and tone of voice evokes "stubbornness and resistance" and a desire to defend on point of view: "It's me versus her".

Wanting to "move on to the next point" or to find some "common ground" so that "we could agree on and move on."

Impact: a bit of shift in thinking, but couldn't utilise exercise as best as could because his point of view dismissed/ not explored. Wanting her to be more "subtle with her probing"

C3:   The therapist "clearly had a different perspective". Trying to "bring me around to her way of thinking". Manner: hinting, leading questions, high pitched tone of voice expressing disagreement with his point of view.

Resulted in trying to downplay/ "dampen down own views" in search for a common ground.

Worrying what the therapist thinks of "you as a person". Don't want therapist to "not like you".

Did becoming more flexible in his thinking initially, but this was not sustained. Feels that he "Would have responded better" if she didn't raise her voice. Could have been "more gentle and subtle."

C8:   Feeling persuaded to "make a certain decision". Preferred the therapist to examine the pro's and con's in a balanced way

Not feeling able to consider points of view for himself.

Appendix J: Excerpt from respondent validation summary

Excerpt from C7's summary

Coming up with ideas that are "personally beneficial"

There was a point in the session where you were discussing some ideas that you held before therapy had helped you to manage your thoughts. One was about making the distinction between your thoughts and the reality of a situation. Your therapist agreed that this was a helpful idea, and built on this idea further through his questioning. This was very significant for you and it reflected a process in the therapy that you found extremely helpful in which your therapist gave credence to your pre-existing ideas about what might help, and used these to generate personalised ways of helping you manage your difficulties.

This way of working made you feel that the therapist was not rigidly applying a set of techniques one after the other, but that the therapist was interested in understanding you, and was open and responsive to your ideas and suggestions. You felt that this resulted in the generation of ideas that were tailored to your needs, and therefore would be more helpful than generic techniques, and this way of working also boosted your confidence in your ability to contribute to the development of useful ways of managing your difficulties.

Identifying unhelpful thinking habits

In the session your therapist suggested some labels (catastrophising and mind-reading) for the thinking habits you were displaying. These labels and the descriptions of these resonated with you, in that you felt that they accurately represent patterns of thinking you typically engage in.

You said that your therapist providing these labels reassured you that he understands you well, and you spoke of this leading you to feel "lucky to be his client". Your therapist then went on to discuss how you might be able to take a step back from your thinking, which you also found helpful.