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1 Manuscript title: Clients' Experiences of Shared Decision-making in an Integrative
2 Psychotherapy for Depression

3 Running title: Clients Experiences of SDM in Psychotherapy

4 Authors: Dr Adam Gibson; Prof Mick Cooper, Dr John Rae & Dr Jacqueline Hayes
5 Corresponding author e-mail: Adam.Gibson.pp@gmail.com
6 Corresponding author telephone: Telephone: +44 (0)20 8392 3741
7 Corresponding author postal address: Department of Psychology, University of
8 Roehampton, Whitelands College, London, UK, SW15 4JD.
9
10 All authors are affiliated with the Department of Psychology, University of
11 Roehampton, London, UK, where these works were carried out.
12

Summary

Mental health and general healthcare research has shown that practitioners can facilitate patient involvement in shared decision-making (SDM) and that the approach can benefit patients who wish to take part in decisions around their care. Yet, patient experiences of shared decision-making within a psychotherapy context have been little researched. This study examined how clients experienced shared decision-making in a collaborative–integrative psychotherapy.

A grounded theory approach used interpersonal process recall interviewing and supplementary semi-structured interviews to investigate 14 clients' experiences of SDM in pluralistic psychotherapy for depression.

Verbatim transcripts were coded into 819 meaning units across six categories containing 13 sub-components that comprised a single, core category. The six categories were: (a) Experiencing decisions as shared, (b) Psychotherapists supporting clients to become more active in the decision-making process, (c) Both parties presenting and recognising expert knowledge, (d) Clients felt recognised as an individual and accommodated for by their psychotherapist, (e) Clients felt comfortable engaging with the decision-making process, and (f) Daunting for clients to be asked to take part in decision discussions. A core category emerged of: "Psychotherapists encourage client participation and progressively support clients to provide information and contributions towards shared treatment decisions that could be led equally, or marginally more by one party". Such support was particularly useful when clients had difficulty contributing as part of decision discussions.

Client preferences for shared decision-making change across clients and across decisions, highlighting the importance of practitioners remaining flexible to individual clients when using the approach.

Keywords: shared decision-making; client experience; interpersonal process recall; communication; psychotherapy; counselling.

40 There is limited research examining shared decision-making (SDM) [1 2 3] in a
41 psychotherapy context. However, mental health and psychotherapy findings show
42 that some clients do want to take part in their treatment decision-making. Adams [4],
43 for instance, found that adult clients from community care settings who lived with
44 severe mental illness wanted more involvement in their psychiatric care decisions
45 than they had previously experienced. Similarly, Kenny[5] presented an interpretative
46 phenomenological analysis of interviews with five psychotherapy clients, with
47 reports that they expected to hold a central, collaborative role throughout treatment
48 alongside their psychotherapist.

49 Experiences of SDM in psychotherapy may differ from experiences in other
50 healthcare contexts. Psychotherapy decisions can be relatively complex, addressing
51 such issues as how the psychotherapy dyad works together or how a conversation
52 may happen, the methods used and content of individual sessions, and more
53 structural decisions such as times of appointments. [6] Such decisions are usually
54 framed around the client's difficulties, identified through joint exploration or
55 psychotherapist interpretation. [7] Psychotherapists and clients then work together to
56 resolve these difficulties in subsequent psychotherapeutic interactions. [8] By contrast,
57 the majority of healthcare decision-making may involve less abstract decisions
58 whereby patients report symptoms to a practitioner in seeking a solution for a
59 difficulty. [9] A treatment or treatment options can then be put in place by that
60 practitioner, or the patient referred to a specialty practitioner. An exception within
61 healthcare is the continual shared decision-making relationship suggested in
62 managing long-term conditions. [10]

63 Meta-analytical data suggests that accommodating clients' preferences in
64 psychotherapy decisions can be beneficial. Swift et al. reviewed 53 studies that
65 examined the impact of accommodating for client preferences on treatment outcomes
66 and dropout. [11] There was a small, significant effect size on treatment outcomes in
67 favour of preference accommodation in psychotherapy. They also showed across 28

studies that clients who were not matched to their preferred treatment conditions were 1.79 times more likely to dropout than those that were matched.

However, there remains a lack of research exploring client experiences of shared decision-making in psychotherapy. Findings from one study are available from a grounded theory analysis of family psychotherapy in a Norwegian outpatient setting. [12] Families reported one helpful aspect of their treatment was having choice around the organisation of the therapeutic work. These choices included how, where, when, and with what psychotherapist to work with. Families also felt collaboration was part of a helpful relationship with their psychotherapist. This consisted of families feeling their psychotherapist had listened to them, heard them, took them seriously, and gave them opportunities to pursue preferred goals and methods. This suggests that these clients had both a desire to be involved in their treatment decisions and found doing so to be helpful.

Research in mental health and general healthcare can help inform an understanding of how clients might experience SDM in psychotherapy. For example, Duncan et al. reviewed studies examining SDM interventions in mental health contexts. [13] They reported one study that showed a SDM intervention to have a positive impact on patient treatment satisfaction, and another that did not. They also concluded that no studies measured patient satisfaction with decisions, nor patient experiences of their interactions with their practitioner during SDM. Later, Brom et al. reported that patients in a cancer outpatient context felt they were involved in their treatment decision-making and were satisfied with it. [14] Additionally, Thompson and McCabe reviewed practitioner-patient communication across 23 studies in mental health contexts to determine any impact on treatment adherence. [15] Their narrative synthesis showed shared decision-making and collaborative communication is associated with greater treatment adherence. Further, a lack of patient-perceived shared decision-making has been associated with antidepressant non-adherence and early non-persistence. [16]

96 Healthcare evidence also shows that practitioners can facilitate patient
97 involvement in shared decision-making through the types of responses they give and
98 the questions they ask. For example, Henselmans et al. examined cancer patient
99 experiences of shared decision-making with oncologists in a palliative care setting. [17]
100 This showed that patients provided additional “preference talk” when oncologists
101 replied with empathy, checking questions, or reflected a patient’s preferences. In
102 other instances, patients did not offer further preference talk when their oncologist
103 provided neutral responses or personal agreements.

104 Most recently, Samalin et al. reviewed the effects of shared decision-making
105 interventions and decision aids on patients living with mood disorders. [18] They
106 presented evidence from randomised control trials in two primary care settings [19 20]
107 one outpatient setting, [21] and one pharmacy routine practice setting [22]. Samalin et al.
108 reported that intervention groups, compared to controls groups, had greater patient
109 participation and satisfaction, [19 20] greater medication adherence and treatment
110 satisfaction, [22] greater patient and physician comfort with the decision made, [19]
111 greater overall functioning, and reduced depression symptoms at six months and 12
112 months. [21]

113 Research examining shared decision-making across helping professions has
114 offered findings showing the approach could have a positive impact on client
115 experiences of psychotherapy and treatment outcomes. Therefore, it would be useful
116 to develop a direct understanding of client experiences of the approach within a
117 psychotherapy context. To develop this, this study aimed to build a comprehensive
118 account of client-reported experiences, guided by three research questions:

119 1. How did clients experience the shared decision-making process in
120 psychotherapy?
121 2. What was the impact of the shared decision-making process on the
122 client?

3. What elements of the interaction during the decision-making process did clients find helpful for facilitating shared decision-making?

Method

Design

This investigation used a qualitative design. Data were collected using cued-recall and semi-structured interview methods within a Grounded Theory approach [23] [24] and analysed via a grounded theory method adapted for psychotherapy research. [19] The use of the two interview methods within a grounded theory approach served first to improve the accuracy in which participants recalled decision-making events, and second, to follow up on those decisions and any emerging decisions occurring later in treatment.

Participants

Participants were the first 14 adult clients referred to a university research clinic. All clients took part in an assessment before interview. Clients were seeking treatment for depression and had a Patient Health Questionnaire-9 score at assessment greater than or equal to 10. [25] The 14 clients were undergraduate or post-graduate students; and had a mean age of 21.6 years old and ranged from 18 to 34 years. A majority of clients were female (71.4%, *n*=10). In terms of ethnicity, clients were predominantly white, British (78.6%, *n*=11), followed by other, Mixed (7.1%, *n*=1), and unknown (14.3%, *n*=2). Three clients reported living with a disability (21.4%). A minority of clients were taking anti-depressant medication at the time of assessment (35.7%, *n*=5). Clients completed an average of 14.5 weekly sessions, out of a maximum of 24. Clients were not required to attend a minimum number of sessions. Over half of clients had planned treatment endings (57.1%, *n*=8). The other six clients ended treatment due to self-discontinuation of treatment, non-attendance, or situational factors such as address re-location.

Procedure and Materials

150 **Pluralistic psychotherapy for depression.**

151 Pluralistic psychotherapy for depression (PfD) is a manualized,
152 collaborative–integrative psychotherapy, [26 27] with evidence of acceptable treatment
153 outcomes. [28] It consists of one 90-min assessment session followed by up to 24
154 sessions of one-to-one psychotherapy. In PfD, the psychotherapist draws on a range
155 of established methods (e.g., active listening, Socratic dialogue) with the aim of
156 tailoring the intervention to the specific goals and preferences of the client (Cooper
157 & McLeod, 2011). As such, PfD strongly encourages the use of SDM, or
158 "metatherapeutic communication", [29] throughout the psychotherapy (including at
159 assessment), to help establish goals, tasks, and methods for the therapeutic work.
160 This is supported through the use of two "decision tools": the Goals Form, [30] a brief
161 goal-setting and monitoring measure; and the Cooper–Norcross Inventory of
162 Preferences (C-NIP), [31] an 18-item measure which invites the client to indicate their
163 psychotherapy preferences on a range of dimensions (e.g., "Focus on my past" vs.
164 "Focus on my future").

165 PfD assessment sessions provided an opportunity for psychotherapists and
166 clients to meet; and for psychotherapists to provide clients with an overview of the
167 treatment. Psychotherapists and clients then had an opportunity to explore the
168 clients' concerns and historical background; and to discuss goals, tasks, methods,
169 and other contractual issues for the psychotherapy. [32]

170 The PfD intervention was delivered by eight psychologists: five females and
171 two males; three fully qualified practitioners and four doctoral level trainees on
172 counselling psychology programmes (data on the eighth psychotherapist were not
173 available). The psychotherapists had been trained in a range of methods, including
174 humanistic, psychodynamic, and CBT; and all subscribed to a pluralistic model of
175 practice. Psychotherapists were asked to study, and practice in line with, the
176 pluralistic psychotherapy for depression manual. However, no specific skills training
177 on this model was given and adherence to PfD was not formally assessed.

178 **Interpersonal process recall.**

179 This investigation used a cued-recall interview method (Interpersonal Process
180 Recall; IPR) to help clients remember and report their experiences. [33 34 35] This
181 method uses audio or video recordings of an interviewee's previous interactions as
182 cues to help them generate rich observations of their experiences. The IPR method
183 has previously shown validity and reliability. Elliott et al used ratings of helpfulness
184 and empathy during IPR interviews to show internal reliability across ratings (α=.5
185 to .66). [36] Others have indicated adequate convergent validity through positive
186 correlations between psychotherapist and client ratings of helpfulness. [37 38]
187 However, Elliott suggests the IPR method is associated with much variability in
188 responses. [34]

189 Clients took part in IPR interviews following their psychotherapy assessment
190 and immediately prior to their first treatment session. This provided immediate
191 support for the client, should they have experienced any distress from revisiting
192 recordings of their assessment session. IPR interviews lasted 70 to 90 minutes,
193 although one interview was shorter and lasted 50 minutes. Interviews began with an
194 explanation of IPR, the purpose of the interview, and what would be expected of
195 clients in taking part. Next, clients had the opportunity to practice the IPR method
196 with an example audio unit. A client would then play and pause audio units on a
197 handheld device, offering commentary on the recording. Providing this control over
198 the device follows IPR recommendations towards helping participants to feel safe
199 and encouraging open, honest responses. [27] Questions and prompts were used
200 throughout the interviews in response to a client, or if the client did not initiate an
201 observation.

202 **Decision-making audio units.**

203 To select units of audio for interview playback in the IPR interviews, the first
204 author reviewed audio recordings of the clients' assessment sessions. IPR suggests
205 that this approach to audio unit selection is appropriate for examining specific events

[38] and should be interpersonally weighted, that is, containing exchanges of talk between both psychotherapist and client, rather than talk from a single speaker only. [39] Units were selected if they contained talk relevant to psychotherapy decisions: for instance, talk about psychotherapy goals, preferences, methods, therapeutic contracts, or session practicalities. [27] Audio units were not constrained by length of speech or numbers of speaking turns, but by topic shift: for example, if the discussion moved from discussing a psychotherapy goal to discussing a possible time for appointments.

IPR question and prompt sheet.

The interviewer asked clients questions and prompts following the clients' playback of audio units. Questioning focused on past experiences, rather than the clients' present thoughts and feelings, to help clients respond to audio units and questions as an observer. [40] This observer focus was further maintained through using sentence stems such as "As you reflect on that moment in psychotherapy…" and "taking a step back from that moment…".

Prompts and questions were informed by existing psychotherapy and IPR literature.[24 27 34 40 41] Example questions include: "What was your role in the interaction?" and "What were your impressions of the psychotherapist's actions at that point?"

Supplementary interview schedule.

Eleven clients took part in supplementary, semi-structured interviews immediately before their fifth treatment session. These interviews lasted between 30 and 58 minutes. Three clients were unable to attend these interviews due to unplanned treatment endings (*n*=2) or limited client availability (*n*=1).

The purpose behind these supplementary interviews was to clients to re-examine assessment decisions and any emerging decisions from the first four treatment sessions. These interviews served to supplement the cued-recall interviews by gaining client perspectives on their decisions now and the evolution of those,

234 rather than observations of the how decisions occurred during assessment. Decisions
235 discussed during interview included those made at assessment and review using the
236 Goals Form and the Cooper-Norcross Inventory of Preferences. Therapists explained
237 to clients during sessions that these forms were tools that could aid decision-making
238 in how the dyad were to work together. Questioning investigated any changes to
239 decisions since assessment or new decisions, the extent to which these were viewed
240 as shared previously or upon change, as well as the relevance and importance of
241 these decisions. Questioning also included subtle decisions such as participation in
242 extra-therapeutic activities or discussion topics within treatment sessions.

243 **Reflexive considerations.**

244 In terms of biases, all authors had an interest in, and favourable attitude
245 towards, SDM practices in psychotherapy. To control for this, we selected methods
246 that we felt were least amenable to unintentional bias. For example, we adopted a
247 grounded theory approach which starts with creating categories that are descriptive
248 and based on clients' reports, rather than researcher interpretations. [42] In addition,
249 coming from a pluralistic epistemological standpoint, [43] we were committed to
250 maintaining a critical and reflexive stance towards our own assumptions, and an
251 openness to new and unexpected findings.

252 **Analytical method**

253 Transcripts from both IPR and supplementary interviews were analysed using
254 a grounded theory approach adapted for psychotherapy research. [42] Rennie et al.'s
255 method is informed by Glaser and Strauss'steps for performing a grounded theory
256 analysis, consisting of data collection, open categorising, concurrently and
257 systematically collecting data, establishing categories, memoing, and identifying
258 emerging patterns to determine a core category. [44]

259 Data from both IPR and semi-structured interviews were analysed together,
260 except when a distinction between the two time points was considered meaningful
261 due to working towards a comprehensive grounded theory, rather than individual

thematic categories. For example, when clients offered a new perspective on a decision in their supplementary interview that they had not mentioned in their IPR interview, this distinction is made clear. The researcher coded 819 meaning units across the 14 transcripts. These meaning units were used to build a framework of sub-components and subsequent categories that contributed to a single core category. The authors prioritised grounded theory analytical conventions over strict IPR analysis procedures.

Coded meaning units contributing to each sub-component and category were not from exclusive groups of clients or audio units. Therefore, single meaning units of text could be included in more than one category. For example, a client could have perceived the decision-making process within separate audio units from the same session as shared, shared and led more by themselves, or shared and led more by their psychotherapist. The number of meaning units for each category sub-component across clients can be seen in Table 1.

Results

Categories and Sub-components

Six categories and sub-components included coded meaning units from both IPR and supplementary interviews. The exception was the category *Daunting for clients to be asked to take part in decision discussions* as this contained client observations from IPR interviews only. Categories are presented in order of descending frequency, with sub-components to each category presented in kind.

Experiencing Decisions as Shared

Client descriptions of the decisions made by themselves and their psychotherapists were coded as either “shared”, “therapist led”, or “client led”. A majority of client descriptions were coded as “shared” psychotherapist (*n*=193 text units), with all clients describing at least one decision in this way. “Shared” decisions were further broken down into “Shared equally by psychotherapist and

client" (n=96), "Shared, but more psychotherapist led" (n=83), and "Shared, but more client led" (n=14). For example, one client during IPR interview observed the following audio unit from their assessment session as shared equally between both themselves and their psychotherapist. Here, the dyad were finalising a therapy goal:

Psychotherapist: It's difficult to- I can hear it's kind of difficult to describe isn't it?

Client: Mmm, mhm.

Psychotherapist: It's difficult to find the exact words but I do I can picture it.

Client: It's the doing. Yeah, the doing doing doing doing doing.

Psychotherapist: I can picture that doing slightly ac- very active. Slightly obsessive isn't it?

Client: Mhm.

Psychotherapist: Kind of like, a bit stuck in to-

Client: -yeah.

Psychotherapist: I've got to do it, I've got to do it.

Client: Yeah, Yeah. Yeah. Yeah, it's obsessive more than. Like could be a little, compulsive. But I think it's more like- can't think of the word.

Psychotherapist: Excessive.

Client: Yeah

Psychotherapist: Well that seems a good way of phrasing it, in terms of saying why-

Client: -yeah, I think that's perfect.

Psychotherapist: Yeah?

Client: That makes sense at least. For me.

Psychotherapist: So, to understand why I go to a place of excessive, doing-

Client: -of excessive doing.

Table 2 shows the number of times each type of decision was coded, across clients. Moments of shared decision-making from this data have been examined by speaking turn using Conversation Analysis in a subsequent study. [6 45]

318 **Therapists supporting clients to become more active in the decision-**
319 **making process.**

320 All clients felt that their psychotherapists encouraged and supported their
321 activity in decision discussions, and that this facilitated the SDM process. All clients
322 reported this encouragement and support in at least one decision discussion with
323 their psychotherapist. These clients observed this support occurring across four
324 actions, coded as four sub-components.

325 ***Helping clients to articulate opinions, suggestions and wants.***

326 All clients felt their psychotherapists, in at least one decision discussion,
327 helped them articulate their opinions, suggestions and wants. This guidance often
328 occurred when clients were uncertain how to define their treatment wants or goals:
329 "It was obvious that I wanted to feel better, so that's not really a useful answer either
330 so erm, yeah, [Psychotherapist] helped me to say what it is practically that I want to
331 change" (Client A, IPR). Eight clients felt this guiding extended to their
332 psychotherapist offering suggestions based on what that client had spoken about.

333 ***Explicitly inviting clients to contribute.***

334 Thirteen clients saw their psychotherapist as inviting them to make
335 contributions to decision discussions. These invitations were more explicit than
336 psychotherapists *providing opportunities for client input*, or *helping clients to*
337 *articulate opinions, suggestions, and wants*. Clients felt their psychotherapists
338 facilitated their involvement through offering encouraging prompts: "nudged me into
339 writing it a bit, more than outrightly saying 'we should do this'" (Client L, IPR). In
340 addition to verbal invitations, seven clients described formal decision tools as an
341 easier way to present their views in decision discussions "Writing it down and then
342 talking about it was much easier than actually having to directly say" (Client D,
343 supplementary interviews).

344 ***Acknowledging clients' expressed preferences, opinions and suggestions.***

345 Seven clients reported instances of their psychotherapists acknowledging
346 their contributions and reassuring them of the appropriateness of making those
347 contributions: "[Psychotherapist] kind of reassured me that, like, it's okay to make
348 decisions like that and to know what you want out of counselling. So
349 [Psychotherapist] helped me to be able to express my opinions and things" (Client H,
350 IPR). This acknowledgement and reassurance occurred whether the client
351 contribution came from the psychotherapist helping to articulate an opinion or
352 suggestion, an explicit invitation, or a psychotherapist-provided opportunity for
353 input. All of these clients saw this acknowledgement as useful for facilitating shared
354 decision discussions and for encouraging participation in future discussions.

355 ***Providing opportunities for client input.***

356 Three clients reported that their psychotherapists provided opportunities for
357 them to have input in decision discussions: "I wasn't being pushed in any
358 direction… Allowed a space for me to come to more of a decision I guess, than if
359 [Psychotherapist] had been more decisive and I felt more- less able" (Client G,
360 supplementary interview). Other clients felt this space was provided them with
361 opportunity for contributing more of their ideas to discussions: "But then
362 [Psychotherapist] would let me expand where I needed to and prompted further into
363 some things and let me go on in others" (Client I, IPR). These were implicit
364 opportunities for a client to contribute rather than explicit invitations.

365 **Both parties presenting and recognising expert knowledge.**

366 Thirteen clients experienced both themselves and their psychotherapists as
367 sharing specialist knowledge with each other. Clients saw this sharing as useful for
368 facilitating decision discussions as each party learned about the client's preferences,
369 wants, and circumstances, as well as the psychotherapist's expertise and professional
370 recommendations.

371 ***Psychotherapists contributing specialist psychotherapy knowledge.***

372 Thirteen clients saw their psychotherapist as sharing specialist psychotherapy
373 knowledge. These clients found psychotherapist suggestions to be useful for
374 progressing decision discussions. For example, one client felt they did not have the
375 appropriate knowledge to make suggestions in decision discussions:

376 I may be the expert, but I don't know how to apply that knowledge,
377 [Psychotherapist] does. So, it makes sense to just kind of let
378 [Psychotherapist] suggest stuff and me occasionally suggest stuff when
379 I've got a better understanding of what we're talking about. (Client F,
380 IPR).

381 ***Clients demonstrating a willingness to consider psychotherapist expert***
382 ***knowledge.***

383 Thirteen clients saw themselves as demonstrating a willingness to consider
384 psychotherapist suggestions: "I will take into consideration anything
385 [Psychotherapist] says and anything [Psychotherapist] proposes. Because they're the
386 psychotherapist and the psychotherapist is the person with the information" (Client
387 G, IPR). The same client felt they wanted their psychotherapist know these
388 intentions: "I think I would like [Psychotherapist] be aware that I am open to their
389 suggestions. I don't want to come across as a person who's shooting down anything
390 they've said or any ideas that [Psychotherapist] has" (Client G, IPR).

391 ***Clients sharing specialist knowledge about themselves and their***
392 ***preferences.***

393 Twelve clients saw themselves as sharing specialist information about
394 themselves that their psychotherapist did not hold. This included their wants,
395 preferences, and details about their circumstances they felt were important to the
396 decision discussion: "telling [Psychotherapist] my experience, how I felt, my likes
397 and interests. And [Psychotherapist] going from that" (Client E, IPR). For one client,
398 this included how a potential decision could impact their family and friends:

399 "Because obviously like, I know the people involved so I know what will and won't
400 work" (Client I, supplementary interview).

401 **Clients felt recognised as an individual and accommodated for by their**
402 **psychotherapist.**

403 Thirteen client reports contributed to three sub-components that comprised
404 this category.

405 ***Decisions were relevant to and useful for clients.***

406 Eleven clients felt that decisions resulting from a SDM process were
407 meaningful and relevant to themselves and their treatment: "I think it's relevant, I
408 mean obviously [Psychotherapist] didn't pull it out of nowhere" (Client J, IPR). Two
409 clients were asked during supplementary interview if this relevance remained, and
410 both agreed it had. Five clients felt these decisions were important for what they
411 wanted to achieve in psychotherapy: "Because like at the very beginning I was just
412 starting to realise that that was a major issue for me" (Client C, IPR). Other clients
413 felt these decisions made their psychotherapy wants feel achievable: "They're quite-
414 quite achievable. And this is a good idea." (Client A, supplementary interview).

415 ***Clients, their preferences, and their wants were accommodated for.***

416 Eight clients reported that psychotherapist actions led them to feel their
417 preferences and wants were accommodated for in the decision-making process. For
418 example, by a psychotherapist drawing on a client's previously discussed
419 difficulties: "I find it interesting that [Psychotherapist] brought that up but it's there.
420 It's definitely there. And I know I talked about it" (Client E, IPR). Clients felt this
421 accommodation continued beyond assessment when deciding on psychotherapy
422 methods for subsequent sessions: "[Psychotherapist] has been really good at just
423 going with me in terms of where each session's gone and just rolling with it" (Client
424 G, supplementary interview).

425 ***Listened to and understood.***

Seven clients reported that actions from their psychotherapist made them feel like they had been listened to and understood during decision discussions: "I could tell by what [Psychotherapist] was suggesting that [Psychotherapist] was listening to me, my actual real concerns" (Client E, IPR). This extended to clients feeling their psychotherapist had understood their psychotherapy wants: "I think everything [Psychotherapist] said there was- deeply understood perfectly how I felt" (Client G, IPR). This understanding was also true for client preferences: "it was clear that [Psychotherapist] had been listening which was quite cool, like, get my preference" (Client I, IPR).

Clients felt comfortable engaging with the decision-making process.

Observations and reports from eleven clients contributed to this category. These clients felt comfortable presenting their preferences: "I was comfortable there and I think because it was more of a way into the sessions as well" (Client A, IPR). One client attributed their feeling comfortable to the flexibility they saw from their psychotherapist: "I think I would say. I think because I feel [Psychotherapist] gave me so much flexibility and flexibility in terms of how I want it to go about the approach" (Client E, IPR). Four of these clients felt comfortable to challenge or reject psychotherapist suggestions if that client felt their preference was not understood.

In being comfortable to take part in the SDM process, six clients felt it was empowering to be involved in their treatment decisions and to have some control over them. One client reported: "It made me feel empowered, but it also then it made me feel like I was empowered by myself" (Client E, IPR).

Daunting for clients to be asked to take part in decision discussions.

Four clients felt psychotherapist attempts to involve them in the decision discussions were daunting:

I don't know. I think sort of being asked was quite daunting… But you go from sort of quite daunting like "I want support but I don't know what support". And then like, being given that small amount of support like calms you down a bit because you're being shown what support you're getting. (Client C, IPR)

Another client recalled a similar daunting feeling when unable to answer their psychotherapist: "not really sure at this point. So, it's kind of a like a sigh of 'Oh god, I'm being asked what else and I can't really think of anything'" (Client H, IPR). Clients reported this daunting feeling subsiding when their psychotherapist provided additional information on what the decision might mean moving forward.

Core Category

Using grounded theory, a preliminary model emerged from the IPR and supplementary interview data to indicate how clients experienced the SDM process in pluralistic psychotherapy for depression. Drawing on the six categories and their subcomponents, the following core category was developed: "Psychotherapists encourage client participation and progressively support clients to provide information and contributions towards shared treatment decisions that could be led equally, or marginally more by one party".

In pluralistic psychotherapy, clients and psychotherapists hold decision discussions whereby they *present and recognise each other's expertise and knowledge*. When occasionally, clients have difficulty in engaging in decision discussions or it is *daunting for clients to be asked to take part in decision discussions, then psychotherapists progressively support clients to become more active in the decision-making process.* However, psychotherapists also offer such support when clients are comfortable taking part in decision discussion. Consequentially, *clients feel comfortable engaging with the decision-making process* and *feel recognised as an individual and accommodated for by their psychotherapist.*

479 This leads clients *to experience the decisions made as shared* – although these could
480 be led equally, or marginally more by one party. Overall, clients in pluralistic
481 therapy experience a decision-making process in which their therapists encourage
482 their participation, progressively support them when they had difficulty contributing
483 to that process and draw on their expertise to offer perspectives on how the therapy
484 might unfold. This results in a process that clients see as shared, and useful for
485 making treatment decisions.

486 **Discussion**

487 Most psychotherapy clients felt comfortable engaging in the SDM process.
488 These findings are similar to those from general healthcare that have shown patients
489 to be comfortable in taking part in SDM interventions before treatment. [46] However,
490 psychotherapy clients also reported instances where it was daunting to take part in
491 decision discussions. These reports were in a minority of instances, for a minority of
492 clients; but they are important for a holistic understanding of clients' experiences of
493 SDM. It also helps to fulfil the standards of validation for a grounded theory:
494 presenting a comprehensive account that provides generality by being inclusive of
495 variation and applicable to a range of contexts. [44 47]

496 The present analysis offers new findings to show SDM can be a positive
497 experience for clients and their treatment in psychotherapy. Clients felt they were
498 listened to and understood, had their needs and preferences accommodated for, and
499 that the resulting decisions were relevant for themselves and their psychotherapy.
500 These reports share similarities with healthcare patients that felt their shared
501 decisions were relevant, helpful, and useful for themselves and their treatment. [46] The
502 present client reports also share similarities with patients who felt satisfied with their
503 shared treatment decision-making. [14] Together, these findings suggest that
504 psychotherapy clients generally have a positive experience of taking part in SDM.
505 Moreover, the similarities between the psychotherapy and general healthcare

506 experiences of SDM imply that the approach has a potential positive impact across
507 the helping professions.

508 Therapists encouraging and supporting clients—from providing opportunities
509 for client input to explicit invitations—was found to be useful for facilitating SDM.
510 This finding is consistent with Henselmans et al.'s reports of patients offering
511 further preference talking following oncologist empathy, checking questions, and
512 preference reflections. [17] However, clients in the present analysis felt that their
513 psychotherapist providing additional information helped ease the feeling that taking
514 part in decision discussions was daunting. We also found that the use of formal
515 feedback tools may assist clients who want to take part in decisions but are daunted
516 by the task.

517 Clients felt that both parties presenting their specialist knowledge helped
518 facilitate SDM. This suggests that the SDM clients experienced in the present
519 integrative psychotherapy is aligned with formal recommendations for SDM
520 practice. For example, that practitioners should contribute their professional
521 knowledge and clients should communicate their ideas, values, and preferences, with
522 both parties contextualising this information to the client and their difficulties. [1 48 49
523 50] Moreover, the present analysis offers new findings to show that clients found their
524 own willingness to consider psychotherapist suggestions as helping to facilitate
525 SDM.

526 **Study limitations**

527 Three clients were unable to take part in supplementary interviews following
528 their fourth treatment session. This was due to unplanned treatment endings and
529 limited client availability. However, categories began to saturate at the eleventh
530 participant, suggesting that much of the variety in client experiences would be
531 captured without this additional data.

532 There is the potential for clients to have been overtly positive in their reports
533 of SDM. Such demand characterises could have been present as interviews were
534 conducted by a member of the university research clinic team, within the same clinic
535 clients were beginning treatment in.

536 As the research was conducted within the context of an SDM-oriented
537 psychotherapy, the findings may not be generalizable beyond such approaches. This
538 context may also have increased demand characteristics, with clients feeling obliged
539 to endorse practices that they knew were central to their psychotherapy. The lack of
540 standardized training, or adherence monitoring, on SDM, also makes the present
541 findings less easily interpretable.

542 Although this paper considers negative experiences of SDM, it does not
543 cover data on barriers to SDM occurring, or experiences in which SDM did not take
544 place.

545 **Implications for Practice**

546 Our findings provide general support for the use of SDM in psychotherapy.
547 However, we found that SDM could be experienced as being shared without an exact
548 equivalence of inputs from psychotherapist and client. This suggests that
549 psychotherapists should consider SDM a gradient phenomenon, rather than an "all-
550 or-nothing" threshold one, in which levels of sharedness in decision-making can be
551 varied depending on the particular circumstances. In addition, our findings suggest
552 that psychotherapists can play an active role in facilitating the SDM process through
553 providing opportunities for client input, explicitly inviting client contributions,
554 helping clients articulate their preferences, and acknowledging clients' contributions
555 to the SDM process. In addition, while clients' recognised their own contributions to
556 SDM; they also demonstrated an openness, and desire, for psychotherapist expert
557 input.

The present analysis, however, also indicated that some psychotherapy clients can be daunted by SDM practices. We found that, while some clients wanted to be fully involved in decision-making, others wanted the psychotherapist to take the lead. This corroborates findings from the healthcare literature that suggest that not all clients may want to be involved in their healthcare decisions. On this basis, Towle and Godolphin suggested physicians should elicit patient preferences for involvement, as well as for amount and format of information. [50] Similarly, Borrell-Carrio et al. suggest that offering the patient the option of more or less autonomy may be ideal practice; [51] and O'Connor et al. have designed decision-aids to elicit the amount of involvement clients want to have when sharing decisions. [52 53] Such practices may be transferable to the psychotherapeutic context, such that the degree of tailoring, itself, can be tailored to the individual client.

Implications for Further Research

The present analysis provides an understanding of client experiences of SDM, although other methods could offer additional perspectives. Doing so would move the field closer towards a holistic understanding of SDM in psychotherapy. For example, researchers could use IPR interviewing and a grounded theory approach to investigate psychotherapists' experiences of SDM. Such an analysis would be directly comparable to the present analysis. Gaining psychotherapist perspectives would also be useful to understand any gaps between clients and psychotherapists perceptions of leadership in SDM, as previous findings showed perceptions of decision-making leadership can differ between patients and practitioners. [54] Second, the use of ethnomethodology or conversation analysis could examine SDM as it occurs *in situ*. Conversation analysis would offer a third, objective perspective outside clients and psychotherapists views. In all such studies, standardized delivery—and monitoring—of SDM practices would help to enhance the interpretability of findings.

Conclusion

586 Our study found that, in most instances, clients were comfortable taking part
587 in shared decision-making and had positive experiences. Most clients found their
588 psychotherapists' encouragement and support helpful in facilitating this process,
589 particularly when they were having difficulties contributing. Our findings also
590 suggest that psychotherapy clients may have different preferences for how much
591 involvement they want to have in their treatment decisions. Therefore,
592 psychotherapists practicing shared decision-making should strive to be aware of
593 these potential differences in preferences and recognise that decision-making can
594 remain shared even if led more by themselves or their clients.
595

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Table 1

Coded meaning units contributing across interviews and clients

	Meaning units (Clients)		
	All	IPR	Su Inter
Experiencing Decisions as Shared	193 (14)	136 (14)	57
Shared, but more psychotherapist-led decision-making	83 (13)	59 (13)	24
Shared leadership over the decision-making process	96 (12)	64 (11)	32
Shared, but more client-led decision-making	14 (4)	13 (4)	1 (
Therapists supporting clients to become more active in the decision-making process	320 (14)	262 (14)	58
Helping clients to articulate opinions, suggestions and wants	122 (14)	97 (14)	25
Explicitly inviting clients to contribute	152 (13)	125 (13)	27
Acknowledging clients' expressed opinions, preferences and suggestions	41 (7)	37 (7)	4 (
Providing opportunities for clients' input	5 (3)	3 (2)	2 (
Both parties presenting and recognising expert knowledge	197 (13)	123 (13)	74
Therapists contributing specialist psychotherapy knowledge	113 (13)	69 (13)	44
Clients demonstrating a willingness to consider the psychotherapist's expert knowledge	44 (13)	22 (9)	22
Clients sharing specialist knowledge about themselves and their preferences	40 (12)	32 (12)	8 (
Clients felt recognised as an individual and accommodated for by their psychotherapist	117 (12)	69 (12)	48
Decisions were relevant to and useful for clients	64 (10)	26 (9)	38
Clients, their preferences, and their wants were accommodated for	38 (8)	29 (8)	9 (
Listened to and understood	15 (7)	14 (7)	1 (
Clients felt comfortable engaging with the decision-making process	70 (11)	55 (11)	15

744

745

Table 2

Amount of coded descriptions from clients across different decision-making leadership styles.

	Clients	Coded meaning units
Therapist-led (non-shared)	12	37
Shared, but more psychotherapist led	13	83
Shared equally by psychotherapist and client	12	96
Shared, but more client led	4	14
Client-led (non-shared)	10	40

746