‘What works for me?’: the impact of the combination between ‘personal style’ and therapeutic orientation on a client’s experience of therapy

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1. Abstract

Recent research on psychotherapeutic outcome has highlighted cognitive behaviour therapy (CBT) as the preferred psychotherapeutic approach for most psychological problems. There is however considerable evidence supporting the comparative effectiveness of approaches alternative to CBT. Central to this alternative evidence base is the notion that 'personal styles' are influential in determining individual *preferences* for different psychotherapeutic approaches. This study examined the effect of the combination between the 'personal style' of the client and the type of psychotherapeutic approach they receive (more or less directive) on the client's experience of therapy. A second aim of this study was to explore similarities and differences in the way clients with different 'personal styles' construe therapy through analysis of repertory grid data. Thirty participants with diagnoses of anxiety and/or depression were recruited from mental health charities and a local NHS community team. Participants completed a questionnaire measuring the *direction of interest* element of personal style, a self-report questionnaire rating their experience of psychotherapy and a repertory grid exploring their construing of psychotherapy. The study found that the fit between an individual's 'personal style' and the type of therapeutic approach they received was predictive of therapy experience. Analysis of the repertory grids revealed few differences in the construing of participants with different 'personal styles'. The use of a global measure of therapeutic experience was original in research looking at the helpful aspects of psychotherapy. The strengths and limitations of the study are discussed and ideas for future research are recommended.

2. Introduction

2.1 Overview

The Introduction will be divided into two sections. The first section will begin with a brief definition of psychotherapeutic outcome and its measurement since the present study falls within the area of psychotherapeutic outcome research. There will be a summary of the evolution of psychotherapeutic research evaluation, beginning with discussion about the early work of researchers in establishing the effectiveness of psychotherapy through to the debate on the comparative effectiveness of different psychotherapies within the modern day context of evidence-based practice (EBP) in clinical psychology. There are three key arguments in this initial section. Firstly, that it is important to consider both the positive and negative effects of psychotherapy when investigating outcomes. Secondly, when measuring outcomes it may be helpful to adopt a constructivist standpoint which prioritises the client's subjective perspective of the therapy rather than relying solely on objectivist research methods. Thirdly, that it is important to evaluate and compare the differential effectiveness of therapies in a critical fashion when attempting to answer the question *'what works for whom?'* Importantly, this discussion will propose that certain types of therapies and areas of research evidence are becoming increasingly marginalised within the current context of evidence based practice. One such area of research evidence examines the interaction between 'personal style' and psychotherapeutic orientation and the impact that this has on psychotherapeutic outcome. Since this study is underpinned by a constructivist standpoint a Personal Construct Theory (PCT) perspective on therapeutic outcome will be discussed.

The second section will consider the alternative evidence base which identifies the importance of 'personal style' in individuals' preferences for psychotherapy orientation. Evaluation of the existing research in this area will follow on to specifically examine the potential impact of the interaction between 'personal style' and therapeutic orientation on therapeutic outcome. A gap in the existing literature will be identified and the rationale for the current research project will be given.

2.2 Effects of psychotherapy

2.2.1 Defining an effect of psychotherapy

An integral goal of psychotherapy is to help clients facilitate positive changes in their lives. Research assessing outcomes and processes in psychotherapy aims to support therapists in making this goal more achievable. Whereas process research tends to examine what happens in psychotherapy sessions, outcome research examines the presence and size of effects resulting from the processes of psychotherapy (Lambert & Hill, 1994).

In psychotherapy, a therapeutic effect is defined as any change that results as a consequence of the therapy, which is judged to be desirable and beneficial. This effect is valid regardless of whether the change was expected, unexpected, or even unintended (Lambert & Hill, 1994). In contrast, an adverse effect (also referred to as negative effect) is any change experienced by the client judged to be harmful and undesirable. These definitions are however deceptively simple. The definition of a therapeutic effect relates to wider philosophical questions regarding how one should define and measure psychotherapeutic outcome, which in turn influence the type of research paradigm used and the specific requirements of the research design (Barker, Pistrang & Elliott, 2002). The different definitions of success given by those conducting research also have a bearing on whether psychotherapy is found to be effective. Therefore a key issue in outcome research is how to measure change that clients experience during therapy.

One such way of measuring change was suggested by Hollon, Thase and Markowitz (2002), who provided criteria for identifying various time points (response, remission, recovery, relapse, recurrence) at which a therapeutic outcome might be measured. A positive effect would therefore perhaps be characterised as involving a decrease in the frequency or intensity of symptoms (emotional, cognitive, behavioural, physical, social) at any of the identified time points whereas a negative effect would involve an increase in symptoms. Alternatively, a less symptom-orientated approach might seek to understand therapeutic effects by exploring the subjective accounts of clients.

2.2.2 Possible causes of effects of psychotherapy

Research investigating the various factors that effect change in therapy has explored the extent to which positive outcomes depend on therapeutic models, client characteristics, therapist characteristics, and relationship factors (Lambert & Bergin, 1994). A challenge with this type of investigation is disentangling the characteristics of the therapist and client from the therapeutic technique used in bringing about the desired change.

There is some evidence of a large difference in outcome rates across therapists suggesting that both positive and negative effects are to some extent related to the therapist (Okiishi, Lambert, Nielsen & Ogles, 2003; Ricks, 1974). Since research shows that the therapeutic alliance is the most significant variable of therapy success (Horvarth & Greenberg, 1989; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000), it is unsurprising that a lack of therapist empathy was predictive of ineffectual therapy in studies examining therapist characteristics (Lambert & Bergin, 1994). More specifically, empirical research investigating the process leading to both positive and negative effects identified therapist competence and skill in applying techniques as significant in determining outcome (Sachs, 1983).

There are a variety of factors thought to increase the possibility of a positive therapeutic effect. Research investigating causes of therapeutic outcome has distinguished between specific factors (relating to particular therapeutic approaches) and common factors (consistent across different treatment approaches). A more detailed consideration of this debate on common and specific factors in determining outcome will be given later in the Introduction. However, some of the factors generally thought to be causal in bringing about a positive outcome include therapist/client characteristics and behaviours, as well as procedures within the process of therapy itself. In particular, some of these factors include unconditional positive regard, genuineness and empathy (Rogers, 1957), client motivation and participation in therapy (Miller, 1985), cognitive restructuring (Padesky, 1994), affective experiencing (Howard, Orlinsky & Hill, 1970), exploration of internal frame of reference (Tolan, 2003), and behavioural regulation (Corrigan, 1997). It is relevant

to add that different therapeutic approaches emphasise different factors as more or less important and this too will be discussed later in the Introduction.

In contrast, factors that have been positively associated with deterioration in therapy include low self-esteem, low self-concept and ineffectual interpersonal skills of the client. These factors were identified by Lieberman, Yalom and Miles (1973), who in one study found that a third of clients in humanistic therapy groups deteriorated, with the behaviour of the group leader cited as the determining factor. In a study of negative effects in psychodynamic psychotherapy, Piper, Azim, Joyce and McCallum (1991) found that a high concentration of transference interpretations was inversely associated with positive outcome. Similar adverse effects have been reported for a wide range of therapies including CBT. Other unhelpful aspects of therapy identified in analysis of focus group research interviews included a lack of respect, stereotyping, imposition of therapist's views, emotional unavailability of therapist, lack of tension, and unethical behaviour (Clarkson & Winter, 2001). Winter (1996) attempted to move beyond simply identifying discrete factors which cause therapeutic effects by proposing a model for explaining the *process* by which psychotherapy can have negative effects. This model will now be considered in more detail.

2.2.3 A Personal Construct Theory (PCT) perspective on effects of psychotherapy

2.2.3.1 What is PCT?

PCT as developed by George Kelly (1955) postulates that people continually construct and reconstruct their realities in order to make them more predictable. Although this idea had surfaced in other fields from psychotherapy (religion, literature, art, philosophy, politics, media, advertising) Kelly was the first to use this idea as the philosophical basis for his theory of psychology and psychotherapy. Kelly used a metaphor of the person as a scientist formulating and testing his/her individual hypotheses to better anticipate his/her world. Whilst this could be viewed as an overly simplistic view of human personality and behaviour it might also be considered ahead of its time when considering the current popularity of behavioural experiments (which

encourage the individual to test out the beliefs and behaviours underlying their difficulties) in modern CBT. Kelly based PCT upon the philosophical assumption of constructive alternativism, which states that "all of our present interpretations of the universe are subject to revision or replacement" (Kelly, 1955, p.15). Personal Construct Psychotherapy (PCP) derives from PCT and has been applied in the treatment of a wide range of clinical problems. Given the underlying philosophical assumptions informing PCP it is best understood as a constructivist[1] therapy in which the client's view of both their reality and their self is seen as crucial.

2.2.3.2 PCT perspective on effects of psychotherapy

Winter (1996) used PCT to understand through which process psychotherapy can have negative effects and whether they are more likely to occur in certain approaches. Although Kelly viewed therapy as a potentially liberating process of re-construction he also identified that negative emotions will inevitably arise as a client's constructs for understanding themselves (their lives etc.) are to some extent invalidated. Winter proposed that emotions that arise from invalidation lead the client to attempt to avoid further invalidation and that this process can lead to negative effects in therapy. Thus, the client's willingness to embrace the process of psychotherapy is fundamentally important to reducing the likelihood of a negative outcome.

Winter identified three negative emotions that may be evoked during therapy: anxiety, guilt and threat. These emotional labels carry a different meaning within PCP to their meaning in everyday terms. Kelly proposed that anxiety may be experienced during therapy if existing constructs are challenged before viable alternative constructs are developed. Guilt may be experienced if a client considers that they are being required to behave in a way inconsistent with their core role, leaving the client unsure of what

[1] Constructivism asserts that an individual's interpretation of reality is subjective and that the scientist is never independent of the observed world. Constructivists argue that processes inherent in the individual largely determine what is taken to be 'real' (McNamee & Gergen, 1992).

their role is. Finally, therapy can become threatening if the client perceives the therapist to be suggesting wholesale changes to their core constructs.

2.2.3.3 PCT model of helpful/unhelpful aspects of therapy

Winter describes a PCT model of helpful and unhelpful aspects of therapy in which invalidation of constructs is central to understanding the process leading to adverse effects. Invalidation of constructs during therapy prompts awareness in the client that they may need to re-construe and this leads to negative emotions. Winter argues that if negative emotions are experienced as tolerable then a process of reconstruction ensues and a positive therapeutic outcome is likely to follow. However if the intensity of the negative emotions is intolerable to the client then he/she will resist the therapist's approach. If the therapist is sensitive to this resistance and modifies therapeutic procedure then a negative outcome can be avoided. However if the therapist continues to fail to construe the client's construction processes and persists with the same approach then the client will use a variety of strategies to avoid further invalidation. An excessive use of certain construal strategies (constriction[2], dilation[3], loosening[4], tightening[5]) by the client to avoid negative emotions can lead to a negative therapeutic outcome. In summary, helpful events in therapy involve some invalidation of the client's views but within an overall climate of validation whereas unhelpful events involve either persistent invalidation (e.g. by the therapist imposing their model/perspective on the client) or total validation (e.g. lack of any challenge).

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[2] Constriction; the individual constricts their constructions for understanding and anticipating the world in order to manage inconsistencies between new and existing constructions.

[3] Dilation; the individual widens their constructions for understanding and anticipating the world when faced with potential reconstruction.

[4] Loosening; the individual's construct system is open to varying alternative predictions for understanding and anticipating the world.

[5] Tightening; the individual's construct system is limited to testing very few alternative predictions for making sense of their experience, particularly when faced with possible invalidation of their construing.

A key consideration within this model is the therapist's response to resistance from the client. PCP views resistance as a client's understandable attempt to preserve their construct system and recommends that the therapist should respect the viability of this system and adapt their approach in order to avoid excessive invalidation. Therefore, despite the client's imbalanced use of strategies being a major contributor to an overall negative effect, it is the therapist's role in being alert to the client's construal processes that is crucial to achieving a positive outcome and averting a negative outcome. Winter concluded (1996, p. 157) 'to the extent that therapy attempts to impose structures on the client, and disregards the client's own construing, it is potentially harmful'.

2.3 Psychotherapeutic outcome research

2.3.1 The need for psychotherapy evaluation

Since its beginning in the 1950s, the scientific evaluation of psychotherapy has undergone extreme changes with a variety of factors contributing to its evolution. At the mid-point of the 20th century, Hans Eysenck (1952) presented evidence indicating that neurotic patients who received psychoanalysis did not have better outcomes when compared with a group of untreated patients. In his infamous review of literature on psychotherapeutic outcome Eysenck (1952, 1965) concluded that the effects of psychotherapy are small or non-existent and that any effects could be accounted for by spontaneous remission. Despite having since been discredited due to methodological inadequacies, Eysenck's review was significant as it prompted an increase in psychotherapeutic outcome research as psychotherapists attempted to demonstrate the positive effects of their work (Barlow, 2010).

The spread of the scientist-practitioner model underlying the training of clinical psychologists (notably in America) during the 1950s and 1960s led to the development of a variety of methods for evaluating psychotherapeutic outcome (Hayes, Barlow & Nelson-Gray, 1999). The popularity of the scientist-practitioner model, which emphasised that clinical psychologists adhere to the contemporary

scientific methods and procedures in their practice, was part of a wider context in which psychiatry rivalled psychotherapy in the treatment of mental disorder (Moncrieff, 1999). The dramatic increase in the availability (and marketing) of psycho-pharmacological treatments as alternatives to psychotherapy changed the way psychotherapy was evaluated. The preferred method for evaluating medical treatments was the Randomised Control Trial (RCT)[6] and this scientific standard was soon adopted as the preferred research design for evaluating psychotherapeutic outcome. Thus the meta-analysis, which systematically reviews the results of RCT studies, emerged as the most influential method in psychotherapeutic outcome research.

2.3.2 Beneficial effects: Meta-analyses

From the earliest reviews in the 1970s through to the present day, meta-analyses have repeatedly shown that psychotherapy produces beneficial effects. In the first psychotherapy meta-analysis, Smith and Glass (1977) reviewed 400 studies and found that all therapies were more effective than no treatment. Smith, Glass and Miller's (1980) subsequent review of 475 studies also showed that the average treated client improved significantly more than an untreated client, with an average effect size of 0.85. Lambert and Bergin's (1994) meta-meta- (or mega-) analyses revealed that the average effect size of clients receiving therapy compared to clients not receiving therapy was approximately 1 standard deviation. A more recent meta-analysis (Hansen, Lambert & Forman, 2002) found that over half of clients receiving therapy showed clinically significant change whilst other recent meta-analyses (e.g. Wampold et al. 1997; Westen, Novotny & Thompson-Brenner, 2004) continue to support the effectiveness of psychotherapy.

[6] The Randomised Controlled Trial (RCT) is a scientific procedure commonly used in testing the effectiveness of psychological interventions. Participants are randomly assigned to either an experimental or control condition to determine whether a cause-effect relationship exists between treatment and outcome.

Despite the current popularity of meta-analysis it remains only one of many methods of research evaluation and it is not without its limitations. Eysenck (1995, p.110) responded to the growing praise of meta-analysis in establishing the efficacy of psychotherapy by branding the method a 'gigantic absurdity' which 'can hardly command scientific respect'. It is beyond the scope of this report to comprehensively critique the relative strengths and weaknesses of meta-analysis as a research procedure but it is important to note that meta-analyses are not free from bias and that even small violations of the rules can lead to misleading results (Walker, Hernandez & Kattan, 2008). Nonetheless, the place of meta-analysis in the history of psychotherapeutic outcome research is without question. Meta-analytic studies have contributed significantly to the now overwhelming empirical evidence supporting the conclusion that established procedures of psychotherapy are beneficial.

2.3.3 Negative effects of psychotherapy

2.3.3.1 Lack of research

The focus of most of the psychotherapeutic outcome research undertaken has been on the overall positive effects (i.e. effectiveness) of different psychotherapies. As a result, the therapies that are adopted today to treat a variety of clinical disorders are based on a positive research outcome (empirical or otherwise) showing that the therapy type will bring about a positive effect in treating those disorders. This has perhaps been based on the thinking that a positive research outcome means that the therapy type will yield an overall positive effect in reality (i.e. be effective) for most individuals fitting the presentation associated with the clinical disorder. More importantly, there is also perhaps an assumption that where the therapy does not produce positive change, it will have no detrimental effect on the individual. This assumption has meant that research on possible negative effects of different types of therapy has not been prioritised. As a result, even though many therapies claim to be effective not all can claim to be free from producing adverse effects (Winter, 1997). This lack of significant knowledge on the possible adverse effects of different therapy

types presents a potential risk for clients and practitioners alike as there is currently an incomplete understanding of the factors that make an adverse effect more likely.

Lilienfeld (2007) highlighted two sources of evidence as relevant for the study of negative effects: namely, RCTs where the intervention actually makes clients in the treatment group worse compared to clients in the control group; and case study reports of extreme negative effects immediately following an intervention. In reality, RCTs are more widely relied on as a source of evidence as they are more consistent with the objectivist contemporary research paradigm. However, information from case study reports is vital as such accounts provide insight into the subjective experiences of those for whom effectiveness is most important.

2.3.3.2 Bergin's deterioration effect

The issue of negative effects in psychotherapy began to draw attention in the mid 1960s following research evidence presented by Allen Bergin (1966). Bergin carefully examined data from research studies in which no significant differences in outcome had been found when comparing treated and untreated groups. Bergin's findings supported Eysenck's assertion that there were no significant differences between clients receiving therapy and clients not receiving therapy. However, Bergin's analysis revealed greater variance within the treatment group change scores compared with those of the control group (where the spread of scores was more closely clustered around the mean). This led Bergin to conclude that 'psychotherapy may cause people to become better or worse adjusted' (Bergin, 1966, p.235). These findings provided a rebuttal of Eysenck's argument that positive effects of psychotherapy were due to spontaneous remission (Barlow, 2010) but they also provided evidence that some clients receiving psychotherapy experience deterioration. Various other studies using RCT design have also shown that deterioration is lower in control patients, implying that there is a causal link between negative outcome and therapeutic activity (Lambert & Bergin, 1994). However, as with all RCT research findings, it is important to note that this link is implied and the client's deterioration may not have been related to the therapy. The main consequence of Bergin's

evidence was that it contributed to the drive to improve methodologies for establishing the efficacy of psychotherapy. The question of negative effects, however, continued to receive scant attention in studies.

2.3.3.3 Potentially Harmful Therapies (PHTs)

A priority for modern day health-care policymakers is to decide how best to distribute public monies in the provision of psychological treatment. In this context determining the efficacy of different therapeutic models is paramount, and so it is perhaps unsurprising that intensive study of the negative therapy effects has largely been forgotten. Moreover, it is likely that the prevalence of negative effects is underestimated in the research literature since clinicians are less motivated to submit research papers demonstrating negative findings for publication.

However, in a recent article Lilienfeld (2007) reviewed the psychotherapeutic outcome research literature and compiled a list of Potentially Harmful Therapies (PHTs). One aim of this research was to demonstrate that not all therapies can claim to be free from producing negative effects. Lilienfeld identified two levels for categorising PHTs: Level I PHTs were categorised as probably harmful for some clients and Level II PHTs were categorised as possibly harmful for some clients. Level I PHTs included critical incident stress debriefing (CISD), grief counselling for normal bereavement and attachment therapies (e.g. re-birthing) amongst others, whilst Level II PHTs included peer group interventions for conduct disorder and relaxation treatment for panic-prone clients. A possible conclusion from Lilienfeld's categorisation of PHTs is that it is the decision to provide particular types of therapy for certain specific problems that results in negative effects rather than the way these therapies are delivered.

Lilienfeld's approach to evaluating negative effects has sparked a renewed interest in the subject of negative effects. Indeed the American Psychological Association's (APA) updated evidence base template - which informs the development of clinical

practice guidelines - recommends that allocation of psychological treatments should be conducted with due consideration of potential negative effects (APA, 2002).

2.3.4 Differential effectiveness of therapies: Common factors theory

Over recent decades the number of psychological therapies available has increased dramatically (Karasu, 1986) and the focus of debate has shifted from looking at the effects of psychotherapy to investigating which therapies are most effective.

Rosenzweig (1936) quoted the Dodo Bird from Alice in Wonderland to support a common factors theory of psychotherapy outcome. The Dodo Bird Verdict that 'everybody has won and all must have prizes' (Carroll, 1865/1962) conveys that common factors (such as therapeutic alliance, empathy and warmth) have a greater positive influence on the outcome of therapy than specific techniques from different schools of psychotherapy. This notion that all therapies are equally effective has therefore come to be known as the Dodo Bird Verdict. In a contemporary review of comparative outcome studies of different therapies Luborsky, Singer and Luborsky (1975) re-introduced the Dodo Bird Verdict, concluding that specific therapy techniques account for a small proportion of the effect size. More recent analyses have also found no difference between the effect sizes of different treatments (Luborsky et al. 2002; Wampold et al. 1997).

Research investigating the ingredients of successful therapy has also indicated common factors that influence therapeutic success. Lambert (1992) found that only 15% of variance in therapeutic outcome is accounted for by specific techniques whilst Wampold (2001) found that 70% of psychotherapeutic effects are general. In particular, numerous studies have shown that the non-specific factor that most significantly relates to outcome in psychotherapy is the quality of the therapeutic alliance (Horvarth & Greenberg, 1989; Martin, Garske & Davis, 2000; Orlinsky, Ronnestad & Willutzki, 1994).

In the mid 1990s Consumer Reports included questions about psychotherapy in its annual questionnaire (Consumer Reports, 1995). Amongst other findings the survey

results showed that the majority of respondents thought that mental health treatment produces benefits but that no one form of treatment was considered better than any other. This pioneering study was important as it prioritised the evaluation of effectiveness of psychotherapy as reported by the client rather than its efficacy as demonstrated in RCTs (Seligman, 1995). Despite methodological limitations in the study (Seligman, 1995) the results from the 7000 survey respondents provided further support for the common factors theory of positive therapeutic change.

2.3.5 Therapeutic models and evidence based practice (EBP)

Despite the previous dominance of the common factors theory in explaining positive outcomes in therapy, many have argued that specific factors have more influence than previously thought in bringing about positive change in therapy. The specific factor which has received the most attention within psychotherapy outcome research is the type of psychotherapy used. This increased focus on the effectiveness of different types (or models) of therapy is especially apparent given the move towards an evidence based practice (EBP) model adopted in Western health-care systems.

EBP within Western mental health care provision involves consideration by policymakers and service providers of the psychotherapeutic research outcome literature (the evidence base) when deciding which types of therapy will be offered for treatment of different psychological problems. The importance of EBP has long been recognised in America since health-care is funded by insurance companies which want to get the best value for their money. It has been a more recent development that mental health care provision in the UK is now also driven by demand for EBP. A natural consequence of EBP is an increasing pressure on the policymakers, service providers and indeed psychotherapists to determine which types of disorders are most effectively treated by which models of psychotherapy. This drive has been at the heart of the Empirically Supported Treatments (EST) movement, which proposes that there *are* specific therapeutic models that are better suited for specific mental health problems (Chambless & Hollon, 1998; Chambless & Ollendick, 2001).

In the 1990s the Department of Health in the UK commissioned a review of psychotherapy research entitled *'What Works for Whom?'* (Roth & Fonagy, 1996, 2005) to ascertain whether there is scientific evidence to show which therapies are most effective for treating various mental health difficulties. The conclusion from *'What Works for Whom?'* was that CBT was the intervention with clear evidence of efficacy for a host of clinical disorders.

Following on from this, in 2006 the UK government launched the Improving Access to Psychological Therapies (IAPT) programme to increase the availability of psychological therapies for people with mental health problems (Department of Health, 2008). This programme was initiated following the Depression Report (Centre for Economic Performance, 2006) by the health economist Lord Layard, which argued that quick and accessible treatment of people with emotional difficulties would lead to an increase in employment and reduction in the number of people claiming incapacity benefit. The priorities in the Depression Report were for services to deliver therapies which are both cost-effective and evidence-based, with CBT promoted as the preferred choice of psychological therapy. The IAPT initiative is also supported by the increasing influence of The National Institute for Health and Clinical Excellence (NICE), which also recommends CBT as the treatment of choice for the vast majority of psychological problems (NICE, 2005).

This overwhelming support for CBT as the preferred treatment model for the majority of psychological problems has, however, had significant implications on the availability of other types of psychotherapy. The question of 'what else works for whom?' appears to have been forgotten by the policymakers in their drive to roll out evidence-based practices and CBT for the masses. This 'one size fits all' approach has concerning implications; firstly because clients may not be able to access other therapies which may be beneficial to them and secondly, and probably more fundamentally, because the existence of those therapies becomes threatened as they are not practised and developed within mainstream services.

In light of this reality, the ongoing debate about the effectiveness of different therapy models is all the more relevant and the question *'*what else works for whom?' needs to be considered.

2.3.6 'What else works for whom?' (Winter, Metcalfe & Greyner, 2008)

The concern for many psychotherapists in the current climate is that funding for therapies is limited to those which produce evidence consistent with a particular empirical and objectivist research philosophy (Winter, 2006). The current focus on empirical validation in determining which therapies can be accepted as evidence-based privileges therapies with a particular objectivist philosophy, such as CBT (Winter et al. 2008). A major criticism of the EST movement is that humanistic and constructivist psychotherapies are marginalised because they are inconsistent with the prevailing contemporary research paradigm (Bohart, O'Hara & Leitner, 1998). Empirically validated therapies are evaluated using RCTs and contain techniques that match the values of objectivist science. Prioritising RCTs as the gold standard in research design comes at the expense of under-valuing the contribution of process-outcome, qualitative and case study designs to the evidence base. As such, therapies which are not as amenable to more traditional scientific evaluation and are less compatible with quantitative research designs are not recommended as treatment options for many psychological problems. Despite the domination of empirical validation in the current research paradigm and the apparent exclusion of humanistic and constructivist therapies, there is an alternative evidence base highlighting the effectiveness of such therapies.

There is considerable research evidence supporting the effectiveness of constructivist therapies. Despite the contradictory assumptions between constructivist therapies and those of the dominant research paradigm, many constructivist psychotherapists acknowledge that they need to contribute to the research evidence base. A variety of studies have shown that improvement during PCP is equal to that in meta-analyses of other forms of therapy (Metcalfe, Winter & Viney, 2007; Winter et al. 2008) and that

constructivist therapies have greater effect sizes when compared to non-active controls (Holland, Neimeyer, Currier & Berman, 2007; Metcalfe et al. 2007). Further, single case studies and group studies with homogenous client groups (Winter, 2003) have repeatedly demonstrated the effectiveness of PCP. Similar findings have supported the effectiveness of psychodynamic therapies (Anderson & Lambert, 1995; Crits-Chrostoph, 1992), humanistic therapies (Elliot, 2002; Elliot, Greenberg & Lietaer, 2004) and systemic therapies (Sexton, Alexander & Mease, 2004; Shadis et al. 1993). It is plausible therefore that the recommendations affirming CBT as the stand out treatment intervention for most clinical disorders under-value research findings demonstrating the efficacy of other types of therapy.

2.4 An alternative evidence base: 'Personal styles' and therapeutic orientation

2.4.1 An alternative evidence base

Although the psychotherapeutic evidence base continues to bias the scientific study and practice of psychology there is a growing body of evidence promoted by constructivist therapists which offers an alternative perspective for understanding psychotherapeutic outcome research (Neimeyer, Saferstein & Arnold, 2005). Central to this emerging perspective is the notion that different 'personal styles' (epistemological, philosophical, cognitive) are influential in determining individual preferences in psychotherapy. A variety of researchers have produced evidence demonstrating that 'personal styles' influence psychotherapists' preference for different psychotherapeutic orientations. There is not, however, as much research on *clients'* 'personal style' and the impact of this on their preferences for psychotherapy. More importantly however, there is a lack of research looking at whether there is a direct link between 'personal styles', preferences for psychotherapy and psychotherapeutic outcomes. Despite these limitations the existing research on 'personal styles' and preferences for psychotherapeutic orientation will be discussed.

2.4.2 Defining 'personal style': Underlying philosophy and epistemology

Early research on 'personal styles' in psychotherapy (Dent, 1978; Frank, 1968; Goldstein & Stein, 1976) highlighted that patient expectations and staff attitudes were significant determinants of outcome. It was however the research efforts of a group of psychologists (Caine, Wijesinghe & Winter, 1981) working at Claybury Hospital in the 1960s onwards that improved understanding about the relevance of 'personal styles' in individual preferences to psychotherapeutic treatment selection. Caine et al. (1981) argued that individual expectations and attitudes regarding psychotherapy are reflective of more general attitudinal and adjustment strategies which they term the individual's 'personal style'. This research programme has provided consistent evidence that people's preference for different treatments reflect their 'personal styles' (Caine & Winter, 1993). 'Personal style' was initially understood to be a composite of various elements including direction of interest, expectancies of treatment and attitudes towards treatment. However as research progressed these elements were found to be closely related to epistemological and philosophical styles, and so 'personal style' is now better understood as an umbrella term encompassing all these traits.

Research has shown that 'personal styles' derive from underlying philosophical beliefs and epistemologies which serve to inform the individual's overall world view (Winter, 2008). These philosophical beliefs and epistemologies were researched by Royce (1964, 1983), who coined the phrase 'grand epistemic dichotomy' to distinguish between two distinct patterns of personality and philosophical traits across individuals (Arthur, 2000). In a later summary of this dichotomy, fundamental differences inherent to these distinct patterns were identified (Johnson & Miller, 1990; Mahoney, 1991). In particular a distinction was made between constructivist and rationalist philosophical (epistemological) orientations.

Constructivism 'refers to a family of theories that share the assertion that human knowledge and experience entail the (pro) active participation of the individual' (Mahoney, 1988, p.2). 'Constructivists emphasise how each individual creates personal representations of self and world...As a consequence...deeply personal

meanings are given priority' (Neimeyer & Raskin, 2000, p.6). Rationalism on the other hand is an epistemological position within philosophy that holds that the use of reason is the best source for understanding the world we live in. In the epistemic dichotomy proposed above, a rationalist epistemology is associated with an analytic, empirical 'epistemic style' of thinking and knowing and an over-arching mechanistic worldview characterised by scientific assumptions. In contrast, a constructivist epistemology was associated with an intuitive, metaphorical 'epistemic style' and an underlying organismic worldview in which humanistic principles are valued.

Johnson, Germer, Efran and Overton (1988) investigated the epistemological beliefs and personality variables of scientists (including psychotherapists of various orientations) finding that individuals' personalities reflected their overall philosophical worldviews. In particular, they distinguished between mechanistically inclined and organismically inclined persons. Mechanistically inclined practitioners were more objective, orderly, conventional and realistic in their cognitive style compared to organismically inclined practitioners, who were autonomous, creative and fluid.

2.4.3 Defining therapeutic orientation: Underlying philosophy and epistemology

There are a variety of approaches used in the practice of psychotherapy and these different types of approach are often referred to as therapeutic orientation. Each approach has an underlying theoretical orientation consisting of philosophical and epistemological assumptions for understanding human experience. Psychotherapy and counselling approaches traditionally fall under three main categories: cognitive and behavioural therapies, psychoanalytic and psychodynamic therapies, and humanistic therapies. However, more recently these categories have expanded to including constructivist therapies, existential therapies, holistic therapies, transcendental therapies, compassion-focused therapies and many more.

The 'grand epistemic dichotomy' is also relevant in the field of psychotherapy as each therapeutic orientation has underlying epistemological assumptions which are likely to

be internalised by clients during therapy with or without their awareness (Winter, 1996). Empirical 'epistemic styles' assume that knowledge is arrived at through sensual experience and so fit with a behavioural therapy approach where the focus of treatment is to modify observable patterns of maladaptive behaviour through reinforcement (Lazarus & Fay, 1984). On the other hand, a rationalist position privileges the use of reason as the preferred path to knowledge and it is this tradition that underpins modern cognitive therapies (Mahoney, 1988) which seek to modify irrational thinking. Modern cognitive-behavioural therapies are underpinned by a combination of rationalist and empiricist philosophy. In contrast, constructivism (which emphasises the subjective nature of knowledge) underlies a variety of less directive therapy approaches including amongst others PCP, narrative therapy and existential-humanistic psychotherapy. More recently, psychoanalytic approaches have begun to incorporate a constructivist philosophy with more emphasis placed on the person's meanings rather than on the interpretative stance of the analyst (Hoffman, 1991; Mahoney & Marquis, 2002). Constructivist therapy approaches value symbolic representation and emphasise the importance of intuitively attending to feelings (Mahoney & Lyddon, 1988). They are consistent with a metaphorical style of thinking as they prioritise the viability of a person's belief system above its validity (Neimeyer et al. 2005). In essence, the biggest difference between constructivism and rationalist philosophy is that constructivists are more interested in the individual meaning of a client's belief system compared to rationalists, who are more interested in evaluating the extent to which the client's beliefs are valid in correspondence with an external reality (Mahoney, 1995).

2.4.4 Impact of 'personal style' on preferences for therapeutic orientation

Research has repeatedly demonstrated that psychotherapists prefer therapeutic approaches consistent with their epistemic and/or epistemological style. Various authors have argued that cognitive-behavioural therapists have an empirical or rationalist epistemological orientation and objectivist world view compared to less directive therapists, who have a constructivist epistemological orientation and

subjectivist world view (Arthur, 2000). Schacht & Black (1985) found that significantly more behaviour therapists had an empirical epistemic style compared to psychoanalytic therapists, who exhibited a metaphorical epistemic style. Further, psychoanalytic therapists had lower mean scores for rationalism than did the behaviour therapists. The 'worldview' of an individual is also thought to reflect preferences for therapeutic orientation. Namely, individuals with a mechanistic 'worldview' are significantly more likely to prefer behavioural approaches whilst those with an organicist 'worldview' are more likely to prefer constructivist approaches (Johnson et al. 1988). In other research, objectivism-subjectivism was found to be the most significant factor influencing psychotherapists' therapeutic orientation preference (Coan, 1979).

Arthur (2006) compared the epistemological beliefs of cognitive-behavioural and psychodynamic therapists to explore the effect of these on orientation choice. He found that the psychotherapeutic orientation of the therapist affected scores on all measures of 'personal style', thus concluding that 'personal style' influences preference for orientation. Similar research showed that personal construct psychotherapists demonstrated a more constructivist epistemology compared to rational-emotive therapists, who were more rationalist (Neimeyer & Morton, 1997). Research has also shown that cognitive-behavioural therapists are more rationalist in their approach compared to constructivist therapists (Neimeyer et al. 2005; Winter, Tschudi & Gilbert, 2006).

Although various research studies have shown that psychotherapists (and clients) prefer therapeutic approaches consistent with their 'personal style', it does not necessarily follow that the approach is appropriate or more likely to yield a positive outcome. It could be argued that a potential downside of a therapist practicing an approach consistent with their 'personal style' is that it might lead them to project too much of their own ego, values and logic into the therapy (Williams & Levitt, 2007).

2.4.5 Impact of 'personal style' (epistemology) of the therapist on therapeutic practice

Neimeyer et al. (2005) suggest that different epistemological distinctions lead to differences in therapeutic practice. Neimeyer & Morton (1997) explored the relationship between epistemological standpoint and psychotherapeutic orientation to see whether this impacts on the practice of psychotherapy. They found that PCP therapists were significantly more committed to a constructivist epistemology compared to rational-emotive therapists. They also found that PCP therapists described their therapeutic style as closely linked to this underlying ideology.

Further support for the argument that the 'personal styles' of the therapists translates into practice comes from work by Winter et al. (2006), who used repertory grid technique to elicit the personal constructs of experienced psychotherapists of different orientations. Their analysis showed that CBT therapists placed more emphasis on technical aspects of therapy whereas PCP therapists valued personal meaning. This is perhaps because constructivists challenge rationalist assumptions concerning emotional experiences as products of irrational thinking, emphasising instead the importance of exploring and expressing the meaning of emotional experiences (Lyddon, 1990).

Vasco (1994) examined different aspects of therapeutic style and practice in a study of Portuguese therapists and looked at how these aspects related to underlying constructivist epistemology. His main finding was that the amounts of therapeutic structure and direction were inversely related to constructivist epistemology. This is consistent with conceptions of rationalist therapies as more structured and directive where therapeutic practice is orientated towards delivery of guidance and technical instruction. Further, the rationalist therapists are more likely to introduce structured interventions and a large proportion of therapeutic activity will be instigated by the therapist.

In a similar study by Winter and Watson (1999) the work of PCP and CBT clinicians was examined and the procedural and relational components of the two orientations were compared. Transcripts of therapy sessions were analysed, revealing a greater

regard for clients from PCP therapists compared to CBT therapists. This can perhaps be understood in relation to underlying epistemological commitments in that cognitive therapists might emphasise the importance of the cognitions underlying emotions whereas a constructivist therapist might explore - rather than challenge - the meaning of the distress for the client (Mahoney, 1991).

Viney (1994) also studied transcripts of therapy sessions conducted by clinicians of different orientations, finding that client-centred therapies and PCP were characterised by greater acknowledgement of client's distress compared to rationalist therapies. Other relevant research in this area reveals that clients with an internal locus of control are more likely to prefer constructivist therapies (non-directive) than clients with an external locus of control, who are likely to prefer rationalist therapies (Vincent & Le Bow, 1995).

A recurring theme in research on 'personal styles' is that therapists with a particular (rationalist) epistemological style are more likely to prefer to practise cognitive behavioural approaches compared to therapists with a constructivist style. Before considering research on direction of interest as an element of 'personal style', there will first be a brief discussion about how different psychotherapeutic approaches are classified as more or less directive.

2.4.6 Therapeutic orientation as more or less directive

There are now a wide variety of approaches used in the practice of psychotherapy. Each approach has an underlying theoretical orientation consisting of philosophical and epistemological assumptions for understanding human experience. Research distinguishing between underlying theoretical orientations has also consistently revealed that therapists of different orientations differ with regard to the emphasis they place upon providing directions to clients (Hardy & Shapiro, 1985). This has led to different psychotherapeutic approaches being classified as more or less directive.

Directive therapies involve the therapist taking a lead role in the therapeutic conversations, suggested courses of action (interventions) and assignment of

homework tasks. Directive therapies typically involve more structure, both in terms of session plan and overall therapy course outline. Less directive therapies, on the other hand, are relatively unstructured and are characterised by the client taking more of a lead role in the therapy than the therapist. Both directive and non-directive therapies recognise the importance of the therapeutic relationship although directive therapies prioritise specific techniques as equally important to facilitating change.

Since the recent increase in the number of therapists who integrate concepts and techniques from more than one therapy type (Jensen, Bergin & Greaves, 1980) it is probably best to think of psychotherapies as moving along a continuum between directive and non-directive style. However, cognitive and behavioural approaches are often distinguished as more directive and 'action orientated' in contrast to most other therapies (such as psychodynamic, constructivist, humanistic, experiential), which are classified as 'insight orientated' and less directive (London, 1986). A description will be provided in the Method section for which therapy approaches were classified as more or less directive in the current study.

2.4.7 Elements of 'personal style': Direction of Interest

'Personal style' is an approach to living which will manifest in attitudes and expectancies across numerous areas. In the context of psychotherapy treatment selection 'personal style' is made up of three elements: namely, direction of interest, radicalism-conservatism, and expectancies of and attitudes towards treatment. For the purposes of the current study, focus will be given to the direction of interest element. The direction of interest element of 'personal style' derives from the Jungian distinction between introversion and extraversion; where introversion represents an interest in ideas, imagination and subjectivity in contrast to extraversion which represents an interest in science, practicality and objectivity.

Research looking specifically at individuals' direction of interest reveals that this element of 'personal style' relates to underlying philosophical beliefs and also influences therapeutic preferences for both therapists and clients. In an attempt to add

clinical relevance to their theoretical premise (that individual expectations and attitudes regarding psychotherapy are reflective of the individual's 'personal style') Caine, Smail, Wijesinghe and Winter (1982) devised a selection of measures of elements of 'personal style' which they called the Claybury Selection Battery. These measures included the Direction of Interest Questionnaire (DIQ), Treatment Expectancies Questionnaire (TEQ), and Attitudes to Treatment Questionnaire (ATQ).

Since establishing the validity and reliability of the Claybury Selection Battery in psychological treatment selection a sustained body of research has illustrated that both therapist and client preferences for different treatments for psychological problems reflect their 'personal styles' and philosophical beliefs (Caine & Winter, 1993; Caine, Wijesinghe & Winter, 1990). In particular, individuals with an inner-directed 'personal style' (as assessed by the DIQ) are more likely to have subjective concerns and are more likely to prefer therapies with a less directive, more inter-personal focus (Winter, 2008). In contrast, individuals with an outer-directed 'personal style' are more likely to value knowledge derived from the external world and are likely to prefer more directive, structured approaches such as cognitive-behaviour therapy (Winter, 2008).

Winter et al. (2006) used repertory grid technique (Kelly, 1955) to elicit the personal constructs of psychotherapists of different orientations. The repertory grid measured therapists' constructions of their own and other therapeutic approaches and the extent of commonality of construing within and between orientations. Differences between therapists were also explored using measures of 'personal style' and philosophical belief. In particular, significant relationships were found between rationalist beliefs and cognitive therapy and between constructivist beliefs and existential therapy. Cognitive-behaviour therapists were found to be more rationalist in their philosophical stance and more outer-directed in their 'personal style' than psychotherapists of other orientations. Analysis of the grids revealed greater commonality of construing within therapists of the same orientation than between therapists of different orientations. Winter reflected that this might help to explain that disputes between therapists may occur because any challenge to therapeutic orientation is also likely to represent a challenge to their 'personal style' and philosophical beliefs. Finally, grid measures

also revealed a significant relationship between outer directedness and a more unidimensional construct system.

A unidimensional construct system (also referred to as a tight construct system) means that an individual has a tight way of construing. The relevance of tightness (or looseness) of construing in psychotherapy experiences can perhaps be understood from a PCT perspective. PCT proposes that all individuals use their existing constructs to anticipate and understand the world. Since these constructs are the very basis for an individual's experience of reality, it is understandable that people will, where possible, want to avoid invalidation of their constructs. An individual's constructs are used to predict and make sense of the world and so they are continually being tested. This process can be understood in relation to the Creativity Cycle (Kelly, 1955). The Creativity Cycle is a sequence of construction in which the individual moves between 'loosening' and 'tightening' of constructs in order to allow the emergence of new ways of thinking (Burr, 2006). Thus, in order for people to experience (themselves, other people, the world) in alternative, novel ways their construing needs to be loose enough for them to contemplate alternative choices for the action/behaviour they may commit in a particular situation. This is pertinent in the field of psychotherapy since a client's capacity for change or for developing new meanings depends in a large part on the construing of those involved in the therapy. In particular, this construing includes the way the client construes their experience, the way the therapist construes the client's experience and the way in which each therapist and client construe the constructions of the other.

Research showing that the tightness (or looseness) of an individual's construct system relates to their direction of interest may therefore predict a client's experience of therapy, depending on whether the therapy is more or less directive. In particular, if outer directedness is predictive of a positive experience of directive therapy and if tight construing is associated with outer directedness, then, tight construing may be associated with a positive outcome of directive therapy for outer-directed individuals.

2.5 Rationale for present research and potential clinical implications

An important consideration when evaluating different psychotherapeutic approaches, particularly with regard to the "evidence" they purport to offer, is that they contain underlying epistemological assumptions which are likely to be internalised by clients during therapy, with or without their awareness (Winter, 1996). The prospect of contemplating an alternative philosophical view of the world (through therapy) might have a significant impact on clients. In particular, they might fundamentally reconstruct their identity and the fundamental beliefs they have for understanding their world. Whilst this process of re-construing can be a liberating and positive experience for many individuals it can lead to adverse, negative experiences for others.

Some authors have gone further, suggesting that a mismatch in therapist and patient epistemologies can result in therapeutic dissatisfaction (Arthur, 2000). It is therefore important for therapists to be mindful of the client's 'personal style' and philosophical stance, as well as their own, since a dissonance between 'personal style' and therapeutic orientation can lead to dissatisfaction. Given the current dominance of rationalist therapies, it is important to consider whether an inconsistency between the epistemological stance inherent in a psychotherapeutic approach and the 'personal style' of the client receiving therapy can contribute to negative effects.

The link between 'personal style', therapeutic approach and therapeutic outcome has only been demonstrated in a small number of studies. In particular, research has shown that clients' 'personal styles' were differentially predictive of their outcome in behaviour therapy and in group-analytic psychotherapy (Caine & Winter, 1993; Caine et al. 1981). The current study will add to the limited existing evidence base in this area by examining the effect of the combination between 'personal style' and therapeutic orientation on therapeutic outcome. This research will be original as it will use a global measure of therapeutic outcome and it will make a comparison between classes of therapeutic approach rather than individual types of approach. This study also has the potential to be clinically useful as findings might usefully inform understanding when matching clients with treatment approaches.

2.6 Aims and hypotheses

The first aim of this study was to examine the effect of the combination between 'personal style' and therapeutic orientation on outcome. Specifically, the primary hypotheses investigated were as follows:

(i) The fit between 'personal style' and directiveness of therapy will effect therapeutic outcome

(i.i) A greater number of clients with an inner-directed 'personal style' will have a negative experience of directive therapy than clients with an outer-directed 'personal style'

(i.ii) A greater number of clients with an inner-directed 'personal style' will have a positive experience of less directive therapy than clients with an outer-directed 'personal style'

A second aim of this study was to explore similarities and differences in the way clients with different 'personal styles' construe therapy. Similarities and differences were also examined for participants depending on whether they had a positive or negative experience of therapy. There were also some specific secondary hypotheses investigated through analysis of repertory grid data. These were as follows:

(ii) Outer-directed 'personal style' will be associated with tighter construing

(iii) Looser construing will be associated with a more positive therapeutic outcome in less directive therapies

(iv) Looser construing will be associated with a more negative therapeutic outcome in directive therapies

(v) Clients with outer-directed 'personal styles' will construe therapist feedback more favourably than clients with an inner-directed 'personal style'

(vi) Clients with outer-directed ‘personal styles’ will construe therapist direction more favourably than clients with an inner-directed ‘personal style’

3. Method

3.1 Design

A non-experimental correlational design was used since the hypotheses investigate whether there is an association between therapeutic orientation, clients' 'personal styles', and therapeutic outcome. The design was retrospective since the inclusion criteria stated that clients could not discuss experiences of psychotherapy that were ongoing. A prospective design would have involved waiting for clients who were currently undergoing therapy to complete their therapy but given the data collection time constraints on the study a retrospective design was chosen. The Direction of Interest Questionnaire (DIQ; Caine et al. 1981) was used as the grouping variable as participants were divided into either an inner-directed or outer-directed group. The design was not entirely retrospective since the participants' responses on this measure reflected their current 'personal style'.

3.2 Participants

3.2.1 Inclusion and exclusion criteria

The minimum inclusion criterion for participation in the study was an experience of individual psychotherapy for mental health difficulties for clients aged over 18 years old. The initial inclusion criteria for the study also included a psychiatric diagnosis of personality disorder as research indicates that people with a personality disorder have notoriously poorer outcomes with psychotherapeutic services compared to clients with other disorders (e.g. Mavissakalian & Hamman, 1987; Turner, 1987). This criterion was however later changed to include clients with different psychiatric diagnoses (specifically anxiety and depression) in order to increase recruitment to the study. Time restraints for the data collection period dictated that restricting inclusion to people with a personality disorder diagnosis would have led to an insufficient sample size. There were no concerns about extending the inclusion criteria to include clients with different psychiatric diagnoses since the research questions were equally relevant

to those clients. Clients of any gender, ethnicity, religion or sexual orientation were eligible to participate in the study.

Clients were eligible to participate in the study if they were currently in therapy. However, the therapy on which their views were sought could not include their current therapy (i.e. individuals whose only experience of psychotherapy was still ongoing could not participate). This criterion was decided upon because it was considered that evaluation by a client of their experience of therapy before that therapy had been completed was potentially disruptive and interfering. Also, evaluation of outcome prior to completion of the therapy would be less valid as a measure because it would mean comparing participants at different stages in the therapy process.

There was no criterion set concerning the length of time that had elapsed from the client's experience of psychotherapy to them taking part in the study. There was therefore a considerable range between participants. For some participants this time lapse was a period of months whereas for many it was a period of years. There was also no criterion set on the number of experiences of psychotherapy a participant may have had. Therefore whilst many of the participants had experienced one course of psychotherapy others had multiple experiences of psychotherapy. This study focused on experiences of individual psychotherapy rather than group psychotherapy. The main exclusion criteria were clients who could not speak English, clients with a learning disability and clients with a current psychosis. These were decided upon in order to retain the homogeneity of the sample and because completion of the repertory grid required a certain level of cognitive function and understanding of the English language. Clients with a history of violent behaviour were also not eligible to participate in the study.

3.2.2 Screening and recruitment

3.2.2.1 Non-NHS participants

A convenience sample was used to recruit participants from mental health charities in Hertfordshire and from the Community Personality Disorder Service (CPDS) within a National Health Service (NHS) Trust in the Home Counties. The majority of

participants were recruited from charities because the process of obtaining ethical approval for non-NHS participants was less time consuming therefore leaving more time for data collection.

Clients were identified through liaison with the charities. A poster (Appendix 1) was put up in the various charity branches inviting interested clients to participate in the research study. A Participant Information Sheet (Appendix 2) was attached to the poster so that clients could obtain more information regarding what potential participation in the research study would entail. The client's suitability for participation was discussed by the lead researcher and charity staff (who had a closer relationship with clients) prior to confirmation of an appointment with the client. This was done through discussion of the specific inclusion and exclusion criterion items. The managers of the charities also circulated Participant Information Sheets - either via email or in person - to clients whom they thought met the inclusion criteria, informing them of the research. Clients interested in participating then contacted either charity staff or the lead researcher confirming their willingness to participate. The lead researcher also attended numerous support groups, therapy groups and social events (all organised by the charities) to introduce the research study and invite clients to participate.

The clients that decided that they were interested in participating in the research study then contacted the lead researcher or charity staff to arrange a research appointment. The research appointments were conducted at the charity site that was most conveniently situated for the participant. This choice of venue was decided upon because it was familiar to the participant so would help make the research appointment as relaxing as possible. Moreover, if there were any issues following the interview (e.g. participant feeling upset after remembering a distressing experience) a member of the charity staff would be on site to offer support to the participant.

3.2.2.2 NHS participants

Participant recruitment via the CPDS followed a similar process. The CPDS team consisted of a variety of mental health practitioners who each held either a primary

worker or care co-ordinator role for clients referred to the CPDS. Team members were informed of the research study[7] and were asked to approach clients who fitted the inclusion criteria to see whether they might be interested in participating. Potentially suitable clients were given a Participant Information Sheet (Appendix 3) to help them decide whether they wanted to participate in the research study. If clients were willing to participate then a research appointment was arranged at the CPDS site.

3.3 Measures

The research appointment was structured as an informal interview of the client during which he/she would complete a series of measures. Firstly, the client completed a demographic questionnaire to record demographic data which was particular to the client. Secondly, the client completed the DIQ (Appendix 4), which measured the client's 'personal style' as either inner- or outer-directed. Finally, the client completed a two-step process to measure their experience of therapy. The first step comprised a questionnaire recording the type of therapy the client received and their rating of the overall outcome of the therapy (Appendix 5). The second step measured the client's construal process in their evaluation of the therapy through completion of a repertory grid focusing on various aspects of therapy sessions.

3.3.1 Demographic data

Basic demographic data were collected for each participant at the beginning of the research appointment. These data were recorded in the questionnaire which examined the client's experience of therapy (Appendix 5). In particular, information was obtained on the client's gender, age, ethnicity, and psychiatric diagnoses. Collecting demographic data was important as it provided information on potentially confounding variables which might influence the results. This process also enabled the interviewer to establish rapport with the participant and for the participant to settle into the interview.

[7] The field supervisor was the Head of the CPDS

3.3.2 Client's experience of therapy (outcome)

A quantitative self-report method in the form of a written questionnaire (Appendix 5) was used to measure the therapeutic outcome. The questionnaire recorded how many courses of psychotherapy the participant had received, what type of therapeutic approach they received and how many sessions of therapy they received. Those participants who had more than one experience of psychotherapy specified which experience of therapy they wanted to discuss as the focus for the research study. Each therapy experience was classified as more or less directive (see Section 3.6.1).

The questionnaire required the participant to provide a subjective rating of their experience of therapy as negative, average or positive. If participants questioned the meaning of positive or negative then guidance was given that these terms referred to how beneficial or detrimental the therapy was perceived to be[8]. Participants then provided a numerical rating of their experience of therapy on a scale from 1 to 10 (1=Extremely Negative, 10=Extremely Positive). This gave a numerical value to their judgements, providing a means of comparing outcomes across participants. Although participants had the option of recording an average rating, the scale did not have a mid-point rating. This was decided upon because it could perhaps indicate whether participants who rated their therapy as average would lean towards a negative or a positive rating (5 or 6 out of 10) if presented with a forced choice. This forced choice procedure would also simplify the data analysis because respondents could be divided into those reporting a positive outcome and those reporting a negative outcome.

Even though the rating scale was clear, simple and brief it was piloted on fellow trainee clinical psychologists within the University who had experienced psychotherapy. The aim of this pilot was to ask for feedback on the experience of completing the questionnaire. The trainee psychologists commented that the rating scale was easy to understand and since there were no criticisms it was confirmed as the measure of outcome.

[8] The same guidance was given to each client

The study examines the client's subjective perspective of their experience of therapy and so the client's self-report was considered the most appropriate measure of outcome. The advantage of using a self-report method was that it gives the client's own perspective but the disadvantage was that there are potential validity problems which are discussed later in the Discussion section of this study.

Although it might have been preferable to have used established outcome measures *in addition* to the constructed self-report measure, the research team did not have ethical approval to access clients' previous medical notes to find the outcome measures used in therapy. In any case, a psychometric measure showing an improvement in the client's pre to post therapy symptom levels and therefore indicating a positive outcome would be considered less meaningful than if the client's subjective evaluation of the therapy was negative. This measure of psychotherapeutic outcome is consistent with a constructivist standpoint as it prioritises the client's subjective perspective on their experience over possible objective evidence.

The questionnaire measuring psychotherapeutic outcome was constructed for this study because a literature search revealed a scarcity of existing instruments measuring overall experience of therapy in a single rating. There are a variety of research instruments that measure the client's experience of a therapy session but they do not provide an overall rating of whether the client found the course of therapy to be helpful. For example, The Helpful Aspects of Therapy questionnaire (HAT; Llewelyn, 1988)[9] was designed as a post-therapy session measure of therapeutic process rather than an overall measure of psychotherapeutic outcome.

The HAT improved understanding in the field of psychotherapy process research as it distinguished between types of event perceived as helpful in different forms of therapy and revealed differences between the types of events perceived helpful by clients and therapists (Llewelyn, 1988). However, the HAT measured therapy at the session level rather than the course of therapy in its entirety. The Client Change Interview Protocol (Elliot, Slatick & Urman., 2001) is another measure used in research to examine

[9] The HAT asks clients to describe in their own words the most helpful event in therapy and to rate how helpful this event was on a 9 point scale (1=hindering 9=helpful)

different dimensions of the therapy process. It is a qualitative interview schedule that can be administered at the end of therapy to ask about what change the client has perceived during therapy and what were the helpful and unhelpful aspects of therapy. However, the Client Change Interview Protocol adopts a qualitative approach to explore therapy experiences and again does not provide an overall measure of outcome, therefore, it too was not used in the current study.

3.3.3 'Personal Style'

The DIQ measures the 'personal style' of participants as either inner-directed or outer-directed (Caine et al. 1981). As described in the Claybury Selection Battery Manual the DIQ was constructed as a "measure of the Jungian concept of...introversion/extraversion" (Caine et al. 1982, p. 5). Specifically the DIQ was constructed as a distillation of three scales distinguishing between introversion and extraversion. These parent scales included the C Scale of the Kuder Preference Record Personal Form A (Kuder, 1952), the M Scale of the Sixteen Personality Factor Questionnaire (Cattell & Eber, 1957) and the SN Scale of the Myers-Briggs Indicator Form F (Myers, 1962). The DIQ was initially validated by association with the Myers-Briggs S/N Scale (Myers, 1962) using both clinical and non-clinical groups. This association was also validated using criterion groups, e.g. subjects from different occupations thought to require particular direction of interest. A variety of research studies have since demonstrated the validity and reliability of the DIQ as a measure of 'personal style' (Caine & Winter, 1993; Winter et al. 2006).

The DIQ consists of fourteen items each distinguishing between an inner and outer direction of interest. For each item the participant makes a choice between two statements representing either an inner or outer direction of interest. For example, Item 2 in the DIQ requires the participant to choose between the statements 'I think of myself as realistic' versus 'I think of myself as idealistic' where the former statement indicates outer-directedness and the latter inner-directedness. Choices indicating an inner direction of interest are given a score of 2, outer direction of interest a score of 0, and uncertainty (either both choices ticked or neither choice ticked) a score of 1.

The maximum total score for the scale is therefore 28 while the minimum score is 0. Higher scores on the DIQ (>15) indicate an inner direction of interest.

The DIQ was used as the measure of 'personal style' in the current study. Participants completed the DIQ and were then categorised as having either an inner- or outer-directed 'personal style'. Those participants with a DIQ score of 15 or over were allocated to the inner-directed group whilst those with a DIQ score of 13 or less were allocated to the outer-directed group. A DIQ score of 14 would indicate neither an inner- or outer-directed 'personal style' since a neutral response on every item results in a score of 14.

3.3.4 Constructions of therapy

3.3.4.1 Repertory grids: What are they?

Repertory grids are a form of structured interview/questionnaire which can be used to identify how individuals construe different aspects of their world (e.g. relationships, experiences). The results of the interview are recorded in a matrix of rating scores. A repertory grid (Kelly, 1955) was used to measure participants' constructions of therapy in the present study (Appendix 6).

Repertory grid technique was developed as a way of putting PCT (Kelly, 1955) into action and it remains fundamental in the practice of PCP. PCP is informed by an underlying constructivist philosophy focusing on the viability of an individual's constructions rather than their validity. A central assumption of PCT is that a person's understanding of reality is constructed through contrasts (dichotomous constructs) rather than absolute truths (Jankowicz, 2004). The repertory grid provides a measure (or description) of an individual's construct system. Although grids are used as instruments in a variety of applied settings they are most appropriately employed in settings underpinned by constructivist philosophical assumptions.

3.3.4.2 Repertory grids: How are they constructed?

Repertory grids consist of four parts: a topic, a set of elements, a set of constructs, and a set of ratings of elements on constructs (Jankowicz, 2004). The topic is the aspect or realm of the individual's experience to be explored. In the current study the topic was how participants construed their experience of psychotherapy. The elements are examples or instances of the topic. 'Personal constructs are bipolar dimensions which each person has created and formed into a system through which they interpret their experiences of the world' (Fransella, Bell & Bannister, 2004, p.16). To put it more simply, constructs are terms the client uses to make sense of elements. It is the bipolar nature of constructs that informs the meaning of the construct for the individual. The ratings are "numbers on a scale applied to each element on each construct, by which an individual expresses a meaning" (Jankowicz, 2004).

3.3.4.3 Constructing the repertory grid: Elements

Repertory grids are usually constructed through the researcher (clinician) providing the client with a list of elements which fit the topic under investigation. Bipolar constructs are then elicited as the client is asked 'In which way are two elements alike and thereby different from a third element?' (Fransella et al. 2004). The answer to this question provides the emergent pole for the construct. The client is then asked 'In what way does the third element differ from the other two?' This provides the contrast pole for the construct. The repertory grid used in this study was, however, constructed in a previous pilot study (Winter, personal communication) and used supplied elements and constructs.

The elements for the grid were chosen to cover therapy sessions which the client experienced in particular ways. The elements were recorded in the grid in the following order.

- Best therapy session
- Worst therapy session
- Ideal therapy session

- Ineffective therapy session
- Helpful therapy session
- Damaging therapy session
- Feel good therapy session

3.3.4.4 Constructing the grid: Constructs

Constructs were derived from transcripts of focus groups in which people who had received psychotherapy were asked to describe their experiences, both positive and negative, of therapy (Clarkson & Winter, 2001). Wherever possible, when an adjective was used in the group to describe therapy, participants were asked for the opposite of this so that bipolar constructs could be used in the grid. The constructs were recorded in the grid in the following order.

o Understood	-	Misunderstood
o Views accepted	-	Views rejected
o Challenging	-	Not challenging
o Views of therapist imposed	-	Views of therapist not imposed
o Confused	-	Not confused
o Safe	-	Unsafe
o Ethical therapist	-	Unethical therapist
o Real human being	-	Not real human being
o Liked by therapist	-	Disliked by therapist
o Directions by therapist	-	No directions by therapist
o Cared for by therapist	-	Not cared for by therapist
o Felt like a child	-	Felt like an adult
o Categorised	-	Not categorised
o Criticised	-	Not criticised
o Trusted therapist	-	Mistrust of therapist
o Feedback	-	No feedback

3.3.4.5 Completing the grid

In the present study, the grid was completed during the research appointment by asking the participant to rate the elements using a 7 point scale on the 16 supplied constructs (e.g. 1=views accepted, 7=views rejected). Using a 7 point scale meant that the participant could give a midpoint rating of 4 which would be a neutral rating, i.e. if the participant did not think that the particular construct was relevant in the evaluation of the element. In some cases, where the clients did not view the construct as relevant for understanding their experience on a particular element, they chose to leave the rating blank. For the purposes of analysis, midpoint ratings were assigned to all blank ratings.

3.4 Procedure

Once ethical approval had been obtained, local mental health charities and the CPDS were approached to recruit participants to the study (see Section 3.2.2). As soon as participants had confirmed their willingness to take part in the study a research appointment was arranged. The research interviews were conducted in a private room at the participants' local charity base. For participants recruited through the NHS the interviews were conducted at the CPDS site. The appointments lasted approximately between 30 and 90 minutes.

The research appointments began by checking that the participant had had the opportunity to read through the Participant Information Sheet and discuss the study with a professional. At this point the researcher gave the participant time to discuss any queries or concerns relating to the Participant Information Sheet. The participants were then given time to read through a consent form (Appendix 7) and to ask any questions relating to the consent form. Once participants confirmed that they understood the consent form and were happy to give consent time was allocated for general questions relating to the research so that the client felt that they were in an environment where they could discuss their thoughts freely.

The interview proceeded with participants completing the DIQ (see Section 3.3.3). A brief rationale behind the DIQ was given to the participant but this was not elaborated on so not to inform the participant of specific research hypotheses. Participants were next required to complete the questionnaire including a section on demographic information and a section exploring their experiences of psychotherapy (see Section 3.3.1 & Section 3.3.2). Participants first rated their experience of therapy as negative, average or positive before providing a more specific rating on a numerical rating scale. The next stage of the interview was completion of the Repertory Grid (see Section 3.3.4). The majority of participants preferred to complete the grid by providing verbal answers, with the researcher recording their ratings. The final stage of the appointment was discussion of a debrief sheet (Appendix 8). This included advice on who the participant should contact should they have any questions or concerns following the appointment (see Section 3.8.4). Participants were given a £5 gift voucher as reimbursement for their time and travel expenses.

3.5 Analysis of repertory grids

A brief description of the grid analysis software package used to analyse the repertory grid data will be given. The analysis of, and measures derived from, the repertory grids will also be described.

3.5.1 IDIOGRID version 2.4 (Grice, 2006)

The grid analysis software package IDIOGRID was used to analyse the repertory grid data. To test the main hypotheses relating to the repertory grids, single grid Slater analyses (Slater, 1977) were carried out for each of the participant's grid data. IDIOGRID was used to construct average grids for all participants, inner-directed participants and outer-directed participants by calculating the mean grid ratings for each group. Single grid Slater analyses were then carried out on the three average grids to examine similarities and differences in construing of participants with different 'personal styles'. Single grid Slater analyses were also carried out on

particular individual grids and used as the basis for case examples. Once Slater analyses had been carried out for the various grid data, the following measures were then considered:

3.5.1.1 Distances between elements

The distances between the following pairs of elements were considered for each participant and also for the groups using the standardised Element Euclidean Distances (Grice, 2006):

- best session/ideal session
- best session/helpful session
- best session/feel good session
- worst session/damaging session
- worst session/ineffective session
- ineffective session/damaging session

The distance between pairs of elements indicates how alike or different they are construed by the participant. A distance of less than 0.5 implies that the elements are very similar and a distance of more than 1.5 indicates that the elements are very different (Winter, 1992). A distance of 1 is the expected value for the distance between elements.

3.5.1.2 Measure of salience: Sum of squares

The sum of squares accounted for by each element and these scores as a percentage of the total sum of squares, show the meaningfulness of the elements to the participant (Winter, 1992). A high score suggests that the element is salient while a low score indicates that there is little variation in its ratings, and that it may have been rated close to the mid-point on most constructs.

3.5.1.3 Super-ordinate constructs

The constructs which load most highly on the first principal component are viewed as being super-ordinate constructs within the participant's construct system (Winter, 1992). Super-ordinate constructs are higher up an individual's hierarchical construct system and thereby subsume other constructs within the context (Kelly, 1955). The percentage total sum of squares of constructs for participants was also used as a measure of super-ordinate constructs. The sum of squares of constructs has been used as a measure of super-ordinacy in previous repertory grid research (Bannister & Salmon, 1966).

3.5.1.4 Principal component analysis: variance accounted for by principal components

Principal Components Analysis (PCA) is a statistical procedure for summarising the numerical information in a repertory grid. This procedure translates the grid variables (elements and constructs) into a number of components (hypothetical variables) which explain the maximum possible variance within the grid. The percentage of variance accounted for by the first principal component was considered for each participant and for groups of participants. This is a measure of cognitive complexity (Winter, 1992) with high percentages of variance demonstrating that the participant's construing is more simple or one-dimensional and more integrated, which reflect tighter construing, whereas lower scores indicate greater differentiation or complexity and reflect looser construing by the client (Grice, 2006). Conversely, a low percentage of variance accounted for by the second principal component is reflective of tighter construing, whereas higher scores indicate looser construing. The percentage of variance accounted for by the second principal component was also considered as a measure of tightness of construing in this study.

3.5.1.5 PCA plot

The principal component analysis enables a two dimensional plot depicting the relationship between the participant's elements and constructs to be produced; this illustrates the participant's construct system regarding the loadings of each element and construct on the first two components (Watson & Winter, 2000). The constructs (as they are accounted for by component one and two) are shown as vectors on the plot and the elements are shown as points on the plot. Generally, elements that are plotted in the same quadrant are construed similarly, whereas those plotted in opposite quadrants are least similar to each other. The elements that are close to the origin of the plot are less significant to the participant, while the elements that are furthest from the origin are construed most extremely (Grice, 2006; Watson & Winter, 2000).

3.5.1.6 Differences between groups on different constructs

Hypotheses (v) and (vi) examined how favourably particular aspects of therapy were construed. Once the participants had been grouped as either inner- or outer-directed, the grid ratings for particular constructs were examined across groups. The constructs which were compared included 'therapist feedback-no therapist feedback' and 'therapist direction-no therapist direction'. Research on 'personal styles' indicates that inner-directed individuals might prefer less directive therapy so these constructs were chosen for analysis because they are the constructs which perhaps most obviously distinguish between more or less directive therapy sessions.

3.6 Therapeutic orientation

3.6.1 Classifying therapies

As stated above, a self-report method was also used to record the type of psychotherapy the participant received. The responses for all participants were collated and each therapy type was categorised as either more or less directive. Table

1 shows the therapeutic approaches classified as either more or less directive in this study.

TABLE 1

Therapies classified as more or less directive

More directive	Less Directive
CBT	Person Centred
CAT	Art
	Counselling
	Psychodynamic
	Psychoanalytic
	Integrative

3.6.1.1 More directive approaches

The two therapeutic approaches classified as directive in the current study were CBT and Cognitive Analytic Therapy (CAT; Ryle, 1995). Most CBT approaches have certain characteristics which lead them to being categorised as a directive therapy. The current popularity of CBT with service providers can be partly accounted for by its directive, structured nature, making it more replicable for training purposes. The brief time-limited nature of CBT means that the therapist adopts an instructional role helping the client to achieve their goals by close adherence to a disorder specific treatment protocol. The directive nature of CBT is characterised by agenda setting, prescribed session structure, and teaching specific skills/concepts. The use of psycho-education material to explain the emergence of psychological difficulties as a learned process also emphasises a directive approach. Although the therapeutic relationship is acknowledged as important in CBT and collaboration is valued as essential to an effective outcome, the over-arching objective is the teaching of rational problem-solving skills which the client can use following therapy.

CAT combines ideas from cognitive theories, PCT, Narrative Therapy and psychoanalytic theory. Although the CAT model is integrative, incorporating many of

the concepts from constructivist and psychodynamic approaches, its practice is more in accordance with cognitive-behavioural therapies as it is time limited, structured and directive (i.e. involves completion of diary forms, progress charts, diagrams).

3.6.1.2 Less directive approaches

The therapeutic approaches classified as less directive in this study included person-centred therapy, art therapy, counselling, psychodynamic therapy and psychoanalytic therapy. A small minority of participants received long-term therapy that they termed as integrative therapy. The long-term nature of their therapy (all had therapy over one year) and the clarification by participants that they 'had not received CBT' meant that these integrative therapies were classified as less directive in the current study.

Less directive therapies emphasise the importance of the client having freedom within the therapy to express their self with support from the therapist who attempts to work within the client's internal frame of reference. Rather than imposing a pre-determined model for understanding the nature of the psychological distress the non-directive therapist supports the client in finding their own meanings using the core conditions as the basis for the therapeutic relationship. This non-directive stance manifests in sessions as the client leads conversations and prioritises the topic of conversation.

Psychodynamic and psychoanalytic therapies were also categorised as less directive in this study. This is consistent with previous research (Arthur, 2000; Winter et al. 2006) exploring the relationship between 'personal styles' and therapeutic orientation preferences, in which, psychoanalytic therapy was classified as less directive. This is perhaps because the style of psychodynamic therapies is similar to client-centred therapies in that the client is encouraged to talk freely about their issues. This is despite psychodynamic therapies being informed by a different underlying theoretical framework. Another reason why psychodynamic therapies are categorised as less directive is because they do not assume a version of reality in which rationalism is the path to knowledge and so the therapy does not aim to teach a 'normal' way of thinking/behaving.

3.7 Power calculation

An a priori power analysis was conducted to estimate the study sample size using Cohen's conventions for effect sizes (Cohen, 1992). A total sample size of 49 would be required to detect a mean difference accounting to a medium correlation (power of 0.80, alpha error=10%, 1 tailed).

3.8 Ethical considerations

3.8.1 Ethical approval

The majority of participants were recruited from charities as the process of obtaining ethical approval through the University was considerably quicker than from the NHS. Approval for the study to proceed with participants from non-NHS charities was granted by the Psychology Ethics Committee of the University of Hertfordshire in June 2010 (Appendix 9) and approval to proceed with NHS participants was granted by the local Research Ethics Committee in July 2010 (Appendix 10).

3.8.2 Informed consent

Participants signed a Consent Form confirming that they had had the opportunity to read through the Participant Information Sheet and ask questions relating to the information within this. The Consent Form included confirmation that participation was voluntary and that participants could withdraw from the study at any point without needing to provide a reason. Participants were offered a debrief meeting with the researcher following completion of the research study if they wanted to discuss the study's findings.

3.8.3 Confidentiality

Confidentiality was maintained throughout the study. A coding system was used to anonymise all participant information, questionnaire information and interview data.

The Participant Information Sheet and Consent Form informed participants that they had the right to withdraw from the study at any time without giving a reason and without this having any effect on their present or future care.

3.8.4 Minimising distress

The research study examined experiences of psychotherapy so it was possible that participants might recall distressing emotional experiences. In an attempt to minimise potential distress throughout the process participants were informed that the interview could be stopped at any point. Participants were also reassured that the researcher was available to offer them support in the first instance and that the mental health professional (organisation) that recruited them to the study had agreed to be contacted should they feel distressed during the interview. Moreover, participants were given contact details of mental health services and organisations they could access should they have felt that they needed support following the research interview. These contact details were supplied in the Debriefing sheet. The feedback from all participants was that participation in the research study was a positive experience as they felt that their experience was being valued and validated.

3.8.5 Time considerations

The research appointments lasted between thirty and ninety minutes. As some of the participants had difficulty concentrating for long periods of time because of their medication the opportunity for regular breaks was offered to each participant.

4. Results

The Results section will be separated into four sections. The first section will provide demographic information and descriptive statistics of the sample. The second section will examine the effect of the combination of 'personal style' and therapeutic orientation on outcome by testing the primary hypotheses. The third section will examine similarities and differences in the way clients with different 'personal styles' construe therapy. This will be done by testing specific hypotheses using grid measures. The third section will also show overall results from the repertory grid data to consider which aspects of therapy were construed as positive or negative. The fourth section will employ an idiographic approach to analyse repertory grid data, examining individual configurations by comparing case examples.

4.1 Demographic information and descriptive statistics

4.1.1 Age and gender

Table 2 shows the gender distribution within the sample comprised 15 males (50%) and 15 females (50%). The age of participants ranged from 21 to 74 years old, with the mean age of the sample being 48 years old (SD=13.42). The modal age range for the current sample was 40 to 49 years old and 50 to 59 years old. The mean age for males was 51 years old (SD=14.91) compared to 44 years-old (SD=11.23) for females.

TABLE 2

Frequency counts and percentages of the age and gender of the sample (N=30)

		Sample n	**Sample %**
Gender	Male	15	50
	Female	15	50
	Total	30	100
Age	20-29	2	6.5

	30-39	6	20
	40-49	8	27
	50-59	8	27
	60-69	4	13
	70+	2	6.5
	Total	30	100

4.1.2 Ethnicity and psychiatric diagnoses

Table 3 shows the majority of participants were white British (97%) with only one participant of an ethnicity other than white British (3%). Similarly, the majority of participants were from charities with only two participants from the CPDS. Approximately one third (33%) of participants had an anxiety disorder diagnosis, one third (30%) had a depression diagnosis and one third (37%) had a diagnosis of both anxiety and depression. Seven participants also had an additional diagnosis of personality disorder.

TABLE 3

Frequency counts and percentages of the ethnicity and psychiatric diagnoses of the sample (N=30)

		Sample n	**Sample %**
Ethnicity	White British	29	97
	White European	1	3
	Total	30	100
Psychiatric diagnoses	Anxiety	10	33
	Depression	9	30
	Anxiety & depression	11	37
	Total	30	100

4.1.3 Experiences of psychotherapy

Data pertaining to participants' psychotherapy experiences are shown in Table 4. Eighteen participants (60%) experienced a single course of therapy while 12 participants (40%) experienced more than one course of therapy. A total of 17 participants (57%) were classified as having received more directive therapy. In particular, 13 participants received CBT and 4 participants received CAT. The remaining 13 participants (43%) were classified as having received less directive therapy. The less directive therapies included person-centred therapy, psychodynamic therapy, integrative therapy and art therapy. Ten participants (33%) had therapy lasting between six and twelve sessions, 8 participants (27%) had between sixteen and thirty sessions, 6 participants (20%) had forty sessions, and 6 participants (20%) had sixty sessions or more. Seven participants (23%) experienced therapy within the year prior to the research interview, 13 participants (44%) experienced therapy between two and five years prior to the research interview, 9 participants (30%) experienced between five and nine years prior to the research interview, and 1 participant (3%) experienced therapy over ten years before the research interview.

TABLE 4

Frequency counts and percentages of therapy experiences of the sample (N=30)

		Sample n	**%**
Number of experiences of therapy	1	18	60
	2	8	27
	3	3	10
	4	1	3
Number of years since therapy completed	0-1	7	23
	2-5	13	44
	5-10	9	30
	10+	1	3
Number of therapy sessions	6-12	10	33
	16-30	8	27

	40	6	20
	60+	6	20
Type of therapy	*More directive:*		
	CBT	13	44
	CAT	4	13
	Less directive:		
	Person-centred	5	17
	Psychodynamic	4	13
	Other	4	13
	Total	30	100

4.1.4 'Personal style'

Table 5 shows the direction of interest of the sample. Twenty participants (67%) had an inner-directed 'personal style', 9 participants (30%) had an outer-directed 'personal style' and 1 participant (3%) was neither inner- nor outer-directed.

TABLE 5

Direction of interest of the sample (N=30)

	Sample n	**Sample %**
Direction of interest		
Inner-directed	20	67
Outer-directed	9	30
No direction	1	3
Total	30	100

Table 6 shows descriptive information for the DIQ scores of the sample. The mean DIQ score was 17 (SD=6.71) for all participants, 16 (SD=8.14) for males and 18 (SD=5.00) for females. No significant difference in DIQ scores was found between participants of different gender and no association with age emerged.

TABLE 6

DIQ scores depending on gender (N=30)

Gender	N	Range	Median	Mean	SD
Male	15	2 – 24	17	16	8.14
Female	15	9 - 26	17	18	5.00
Total	30	4-26	17	17	6.71

4.1.5 Therapeutic outcome

Table 7 shows the therapeutic outcomes of the sample. Nineteen participants (63%) had a positive experience of therapy, 9 participants (30%) had a negative experience of therapy and 2 participants (7%) had an average experience of therapy.

TABLE 7

Therapeutic outcomes of the sample (N=30)

	Sample n	Sample %
Therapeutic outcome		
Positive	19	63
Negative	9	30
Average	2	7
Total	30	100

Table 8 shows that the mean therapeutic outcome rating for all participants was 6.33 (SD=3.16). There was a small non-significant difference between gender with a mean rating of 6.80 (SD=3.12) for males compared to a mean rating of 5.87 (SD=3.24) for females.

TABLE 8

Therapeutic outcome ratings depending on gender (N=30)

Gender	N	Range	Median	Mean	SD
Male	15	1 – 10	8	6.80	3.12
Female	15	1 - 10	6	5.87	3.24
Total	30	1 – 10	6, 7	6.33	3.16

Table 9 shows the distribution of participants of different 'personal style' receiving different types of therapy. One participant was excluded from this analysis since they were neither inner- nor outer-directed. There was a reliable association between 'personal style' and directiveness of therapy (Chi square=4.92, df=1, p=0.04, 2 sided). The strength of this relationship was medium size, phi=0.41. In particular, whilst inner-directed participants were almost equally likely to have received either type of therapy, outer-directed participants were more likely to have received more directive therapy. It is possible that the 'personal style' of the client influenced the decision (made by either the referrer or the client) to select a particular type of therapy.

TABLE 9

Frequencies and percentages direction of interest and therapy approach (N=29)

	More directive	Less directive	Total
Outer-directed	8 (89%)	1 (11%)	9 (100%)
Inner-directed	9 (45%)	11 (55%)	20 (100%)
Total	17 (59%)	12 (41%)	29 (100%)

4.2 Examining the effect of the combination of 'personal style' and therapeutic orientation on outcome by testing the primary hypotheses

4.2.1 Test of hypothesis (i)

Hypothesis (i) predicted that the fit between 'personal style' and directiveness of therapy will have a significant effect on therapeutic outcome. In order to test hypothesis (i), a new variable was created in SPSS indicating whether there was a positive or negative fit between 'personal style' and type of therapy received. As shown in Table 10, participants in the *main* diagonal (upper left and lower right quadrant) were categorised in the 'positive fit' group, while participants in the *off* diagonal (upper right and lower left quadrants) were categorised in the 'negative fit' group. Participants in the 'positive fit' group were either: outer-directed having received directive therapy or inner-directed having received less directive therapy. Conversely, participants in the 'negative fit' group were either: outer-directed having received less directive therapy or inner-directed having received directive therapy. One participant was excluded from this analysis since they were neither inner- nor outer-directed. Consistent with hypothesis (i), participants in the 'positive fit' group were expected to have a positive therapeutic outcome, whereas participants in the 'negative fit' group were expected to have a negative outcome.

TABLE 10

Positive and negative fit between 'personal style' and therapy approach (N=29)

	More directive	**Less directive**
Outer-directed	Fit 8 (89%)	No fit 1 (11%)
Inner-directed	No fit 9 (45%)	Fit 11 (55%)

The box plot in Figure 1 shows the distribution of therapeutic outcome ratings for all participants in the 'positive fit' and 'negative fit' groups. One participant was excluded from the box plot analysis because they were neither inner- nor outer-directed and therefore they could not be categorised to either the 'positive fit' or 'negative fit' group. Although there was some overlap between the groups,

participants in the 'positive fit' group had higher outcome ratings than the 'negative fit' group. This supports hypothesis (i) as it indicates that positive fit between 'personal style' and therapeutic approach results in a positive outcome. In view of the non-normal distributions, a Mann-Whitney U test (MWU) was used to compare the therapeutic outcomes in the 'positive fit' and 'negative fit' groups. The result revealed a significant difference for therapeutic outcome between the two groups (MWU=55.5, p=0.034, 1 tailed).

FIGURE 1

Box plot of the distribution of outcome ratings depending on 'fit' (N=29)

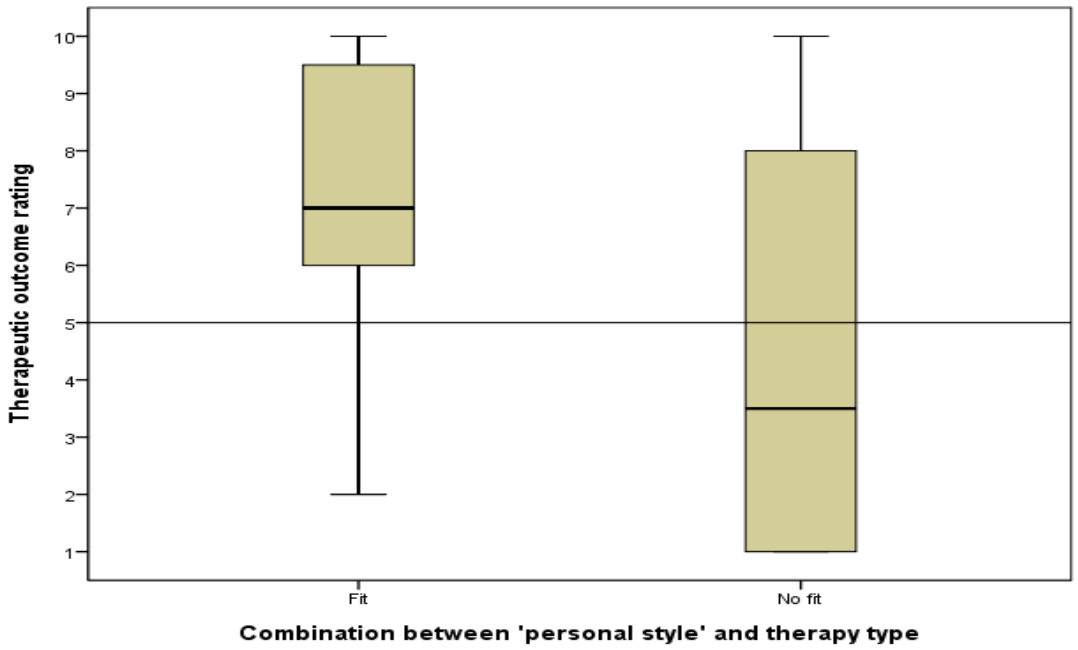


Table 11 shows the mean and median outcome ratings for the 'positive fit' and 'negative fit' groups. Analysis revealed that the 19 participants in the 'positive fit' group had higher mean and median ratings than the 10 participants in the 'negative fit' group. The corresponding effect size was strong (Cohen's d=0.79, CI=-0.001-1.583). Therefore the results supported hypothesis (i) as the fit between 'personal style' and therapy approach did have a significant effect on outcome.

TABLE 11

Mean and median outcome ratings depending on 'fit' (N=29)

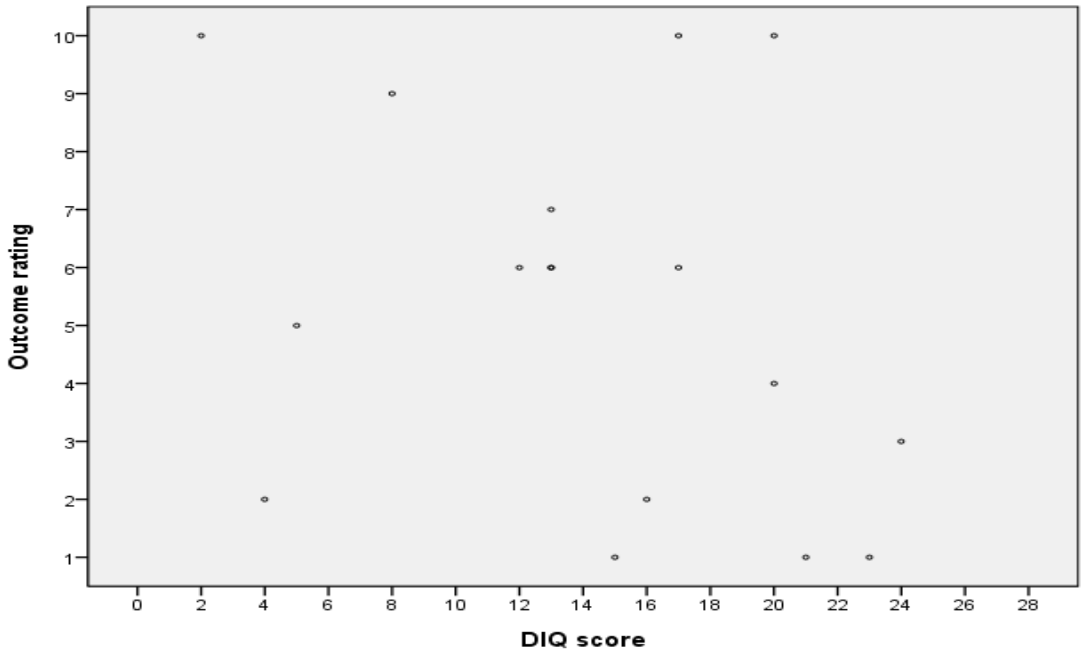
	N	Median	Mean	Skewness	SD
Positive fit	19	10	7.11	-0.61	2.60
Negative fit	10	1	4.60	-0.55	3.66
Total	29	6,7	6.3	-0.34	3.11

4.2.2 Test of hypothesis (i.i)

The scatter plot in Figure 2 shows the individual DIQ scores in relation to the outcome ratings for directive therapy. As predicted the scatter plot shows that outer-directed participants had a more positive experience of directive therapies than inner-directed participants. The corresponding rank correlation indicates a non-significant negative relationship between direction of interest scores and outcome ratings for directive therapy although the p value of 0.08 indicated a trend in this relationship (rho=-0.34, p>0.05, 1 tailed).

FIGURE 2

Association between direction of interest and therapeutic outcome for directive therapy (N=17)



Hypothesis (i.i) predicted that a greater number of inner-directed clients had a negative experience of directive therapy than outer-directed clients. The two participants who rated their experience of directive therapy as 'average' were not included in the analysis for hypothesis (i.i) in Table 12. Table 12 shows that 75% of inner-directed clients had a negative experience of directive therapy compared to 14% of outer-directed clients. The association between direction of interest and therapeutic outcome for directive therapy was analysed using a chi-square test. The test revealed a reliable association between direction of interest and outcome for directive therapy (Chi square=5.52, df=1, p=0.03, 1 tailed). A phi correlation of -0.61 indicated that this relationship was strong. A conditional probability analysis for negative outcome of directive therapy depending on direction of interest was 75% for inner-directed participants versus 14% for outer-directed participants. Conversely, a conditional probability analysis for positive outcome of directive therapy depending on direction of interest was 25% for inner-directed participants versus 86% for outer-directed participants. Hence the percentage difference between inner- and outer-directed groups for negative outcomes of directive therapy was 61% whereas the percentage difference between groups for positive outcomes was 59%. Therefore, hypothesis (i.i) was supported as a significantly higher percentage of inner-directed clients had a negative experience of directive therapy.

TABLE 12

Outcomes for directive therapy depending on direction of interest (N=15)

	Positive	**Negative**	**Total**
Inner-directed	2 (25%)	6 (75%)	8 (100%)
Outer-directed	6 (86%)	1 (14%)	7 (100%)
Total	8 (53%)	7 (47%)	15 (100%)

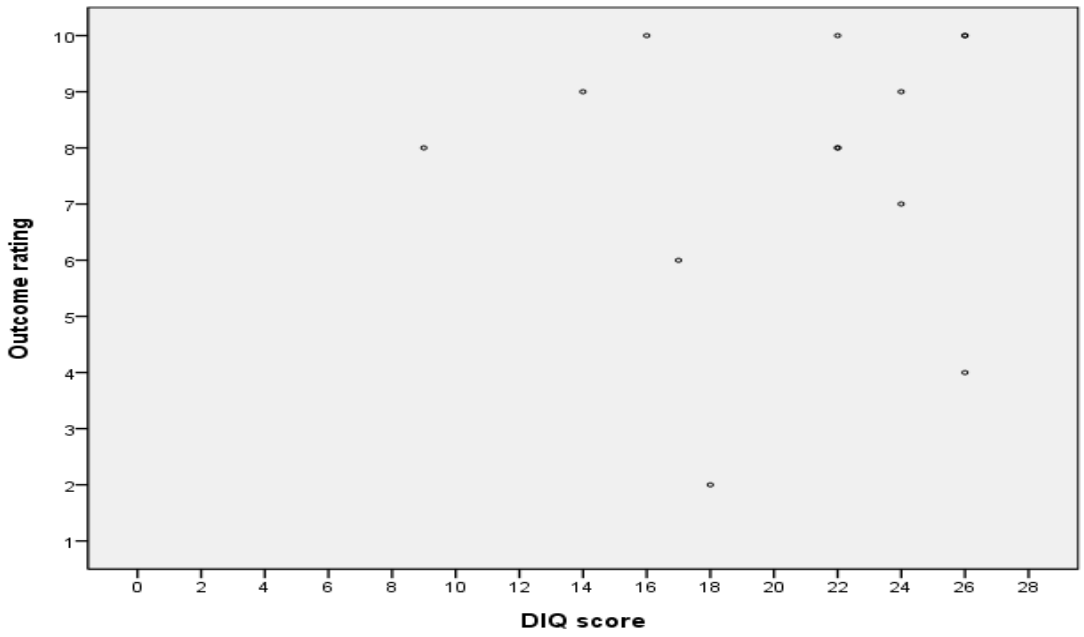
4.2.3 Test of hypothesis (i.ii)

The scatter plot in Figure 3 shows the individual DIQ scores in relation to the outcome ratings for less directive therapy. The scatter plot reveals that inner-directed participants mostly had a positive experience of less directive therapy. Only one outer-directed participant received less directive therapy, therefore the corresponding rank correlation indicates a non-significant relationship between direction of interest scores and outcome ratings for less directive therapy (rho=0.11, p=0.35, 1 tailed).

FIGURE 3

Association between direction of interest and therapeutic outcome for <u>less directive therapy</u>

(N=13)



Hypothesis (i.ii) predicted that a greater number of inner-directed clients would have a positive experience of less directive therapy than outer-directed clients. However, it was not possible to test hypothesis (i.ii) since only one outer-directed participant received less directive therapy, another participant was neither inner- or outer-directed, and another participant rated their experience of less directive therapy as 'average'. The data for these three participants were therefore not included for the analysis of hypothesis (i.ii). Hypothesis (i.ii) was modified to predict that inner-directed clients were more likely to have a positive experience of less directive therapy rather than a negative experience.

Table 13 shows that 90% of inner directed clients (n=10) had a positive experience of less directive therapy. A binomial test was conducted to analyse the proportion of inner-directed clients likely to have a positive experience of less directive therapy. The binomial test revealed that the mean proportion of inner-directed participants who had a positive outcome of less directive therapy was 0.90. The p value of 0.021 (1-tailed) was significant at the 0.05 level indicating that inner-directed clients are likely to have a positive experience of less directive therapy. The null hypothesis of equally likely outcome was therefore rejected.

TABLE 13

Outcomes for less directive therapy depending on inner direction of interest (N=10)

	Positive	**Negative**	**Total**
Inner directed	9 (90%)	1 (10%)	10 (100%)

4.3 Examining similarities and differences in the way clients with different 'personal styles' construe therapy by testing the secondary hypotheses

A second aim of this study was to explore similarities and differences in the way clients with different 'personal styles' construe therapy. This was done through testing specific hypotheses using grid measures and by examining average grids for different groups of participants. Of the total sample, repertory grids were completed for 22 participants. As explained in the Method section, tighter construing was indicated by either a high percentage of variance accounted for by the first principal component or by a low percentage of variance accounted for by the second principal component.

4.3.1 Test of hypothesis (ii)

Hypothesis (ii) predicted that an outer-directed ‘personal style’ will be associated with tighter construing. Analysis of the 22 completed grids revealed that there was no significant relationship between direction of interest and tightness of construing when tightness of construing was measured by the percentage of variance accounted for by

either the first principal component (rho=-0.01, p=0.48, 1 tailed) or by the second principal component (rho=0.11, p=0.30, 1 tailed). Therefore, hypothesis (ii) was not supported.

4.3.2 Test of hypothesis (iii)

Hypothesis (iii) predicted that looser construing will be associated with a more positive outcome in less directive therapies. Analysis of 11 grids revealed that there was no significant relationship between loose construing and therapeutic outcome in less directive therapies when tightness of construing was measured by the percentage of variance accounted for by either the first principal component (rho=0.14, p=0.34, 2 tailed) or by the second principal component (r=0.11, p=0.36, 2 tailed).

4.3.3 Test of hypothesis (iv)

Hypothesis (iv) predicted that looser construing will be associated with a more negative outcome in directive therapies. Analysis of 11 grids revealed a significant correlation between tightness of construing and therapeutic outcome when tightness of construing was measured by the percentage of variance accounted for by the second principal component (r=-0.60, p=0.02, 1 tailed). There was not a significant correlation between tightness of construing and therapeutic outcome when tightness of construing was measured by the percentage of variance accounted for by the first principal component (r=0.45, p=0.08, 1 tailed). However the p value was less than 0.1 indicating that there was a trend in this relationship even though it was not significant. These analyses support hypothesis (iv) indicating that looser construing is associated with a more negative therapeutic outcome in directive therapies.

4.3.4 Test of hypothesis (v)

Hypothesis (v) predicted that clients with outer-directed ‘personal styles’ will construe therapist feedback more favourably than will clients with an inner-directed ‘personal

style'. To test hypothesis (v), mean grid ratings on the 'therapist feedback' construct for the 'ideal session' were calculated for both inner- and outer-directed participants. A rating of 7 indicated 'lots of therapist feedback', a rating of 1 indicated 'very little therapist feedback', and a midpoint rating of 4 indicated 'some therapist feedback'. Table 14 shows the mean ratings of the 'therapist feedback' construct for the 'ideal therapy session' depending on 'personal style'. Of the participants who completed repertory grids, one had a neutral score on the DIQ so they were not included in the analysis for hypothesis (v). The inner-directed participants' mean rating was 5.31 (SD=1.60) compared to the outer-directed participants' mean rating of 5.38 (SD=0.91). There was therefore no difference in the way participants with different 'personal styles' construed this construct as both groups would prefer some therapist feedback. Considering the minimal difference in mean ratings between the groups, tests for significance were not conducted.

TABLE 14

Mean ratings of 'therapist feedback' construct for the 'ideal therapy session' (N=21)

Construct	**Inner-directed (N=13)**	**Outer-directed (N=8)**
	Mean (SD)	Mean (SD)
Therapist feedback	5.31 (1.60)	5.38 (0.91)

4.3.5 Test of hypothesis (vi)

Hypothesis (vi) predicted that clients with outer-directed 'personal styles' will construe therapist direction more favourably than will clients with an inner-directed 'personal style'. To test hypothesis (vi), mean grid ratings on the 'therapist direction' construct for the 'ideal session' were calculated for both inner- and outer-directed participants. A rating of 7 indicated 'lots of therapist direction', a rating of 1 indicated 'very little therapist direction', and a midpoint rating of 4 indicated 'some therapist direction'. Table 15 shows the mean ratings of the 'therapist direction' construct for the 'ideal therapy session' depending on 'personal style'. Again, the participant with a neutral score on the DIQ was not included in the analysis for hypothesis (vi). The inner-directed participants' mean rating was 4.23 (SD=1.36) compared to the outer-

directed participants' mean rating of 4.38 (SD=1.68). Again, there was no difference in the way participants with different 'personal styles' viewed this construct as both groups indicated that an 'ideal therapy session' would involve 'some therapist direction'. Considering the minimal difference in mean ratings between the groups, tests for significance were not conducted.

TABLE 15

Mean ratings of 'therapist direction' construct for the 'ideal therapy session' (N=21)

Construct	**Inner-directed (N=13)**	**Outer-directed (N=8)**
	Mean (SD)	Mean (SD)
Therapist direction	4.23 (1.36)	4.38 (1.68)

4.4 Examining participants' construing of therapy through exploration of average grids

IDIOGRID was used to construct average grids for all participants, inner-directed participants, and outer-directed participants. This enabled detailed examination of commonalities and differences in the way participants construed their experience of psychotherapy.

4.4.1 Average grid for all participants

The average grid analysis for all participants consisted of carrying out a single grid Slater analysis on the average grid for the whole group. The key findings are reported below.

4.4.1.1 Distances between elements

Table 16 shows that participants construed 'best therapy session' in a very similar way to 'ideal therapy session', 'feel good therapy session' and 'helpful therapy session'. Although not displayed in Table 16, 'ideal therapy session', 'feel good therapy session

and ‘helpful therapy session’ were also construed in a very similar way. Unsurprisingly, there was a large difference between the ‘ideal therapy session’ element and the ‘worst therapy session’ and ‘damaging therapy session’ elements. Conversely, Table 16 shows that ‘worst therapy session’, ‘damaging therapy session’ and ‘ineffective therapy session’ were all construed in a very similar way.

TABLE 16

Standardised Euclidean Element Distances for all participants (N=22)

Measure	Distances
Distance best session/ideal session	0.20
Distance best session/helpful session	0.23
Distance best session/feel good session	0.12
Distance worst session/damaging session	0.20
Distance worst session/ineffective session	0.38
Distance ineffective session/damaging session	0.46

4.4.1.2 Measure of salience: Sum of squares

Table 17 shows the percentage of the total sum of squares is higher for participants for ‘worst session’ and ‘damaging session’ elements, which suggests that negative therapy experiences are more salient than positive therapy experiences.

TABLE 17

Participants’ percentage total sum of squares of elements (N=22)

Element	Sum of squares	Percent total of sum of squares
Damaging session	55.16	25.43
Worst session	48.99	22.59
Ideal session	34.75	16.02
Feel good session	26.17	12.06
Best session	22.11	10.19
Ineffective session	20.20	9.31

Helpful session	9.52	4.39

Table 18 shows the percentage of the total sum of squares is higher for participants for the constructs concerning 'trust', feeling 'understood' and feeling 'safe'. These may therefore be considered to be the participants' most super-ordinate constructs.

TABLE 18

Participants' percentage total sum of squares of constructs (N=22)

Construct	Sum of squares	Percent total of sum of squares
Understood	29.96	13.81
Trust	24.69	11.38
Safe	21.87	10.08
Not confused	17.93	8.86
Cared for	18.04	8.32
Views accepted	17.93	8.27

4.4.1.3 Variance accounted for by the first principal component of the construct correlations

The large percentage of variance shown in Table 19, accounted for by first component is suggestive of tight construing and a relative lack of cognitive complexity. However, average grids often have a large percentage of variance accounted for by the principal component so this can also be interpreted as a methodological artefact rather than being suggestive of tight construing (Grice, 2006).

TABLE 19

Percentage variance accounted for by component 1 and 2 for all participants (N=22)

Principal Component	Percentage variance
1	91.71
2	6.14

4.4.1.4 Loadings of elements and constructs on the first principal components

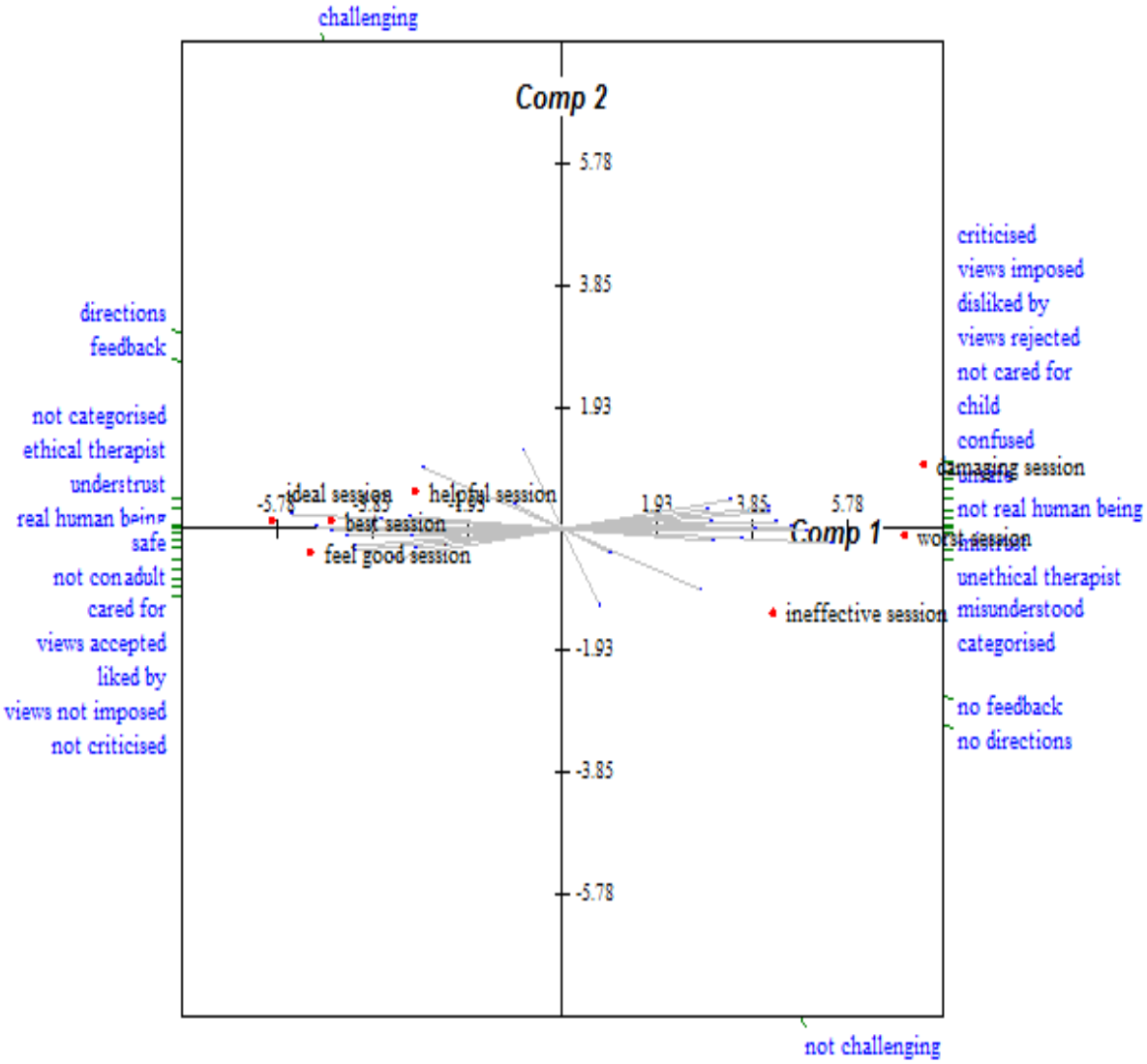
Loadings of constructs on the participants' principal dimension of construing demonstrated that it contrasts sessions in which the client felt 'safe', 'understood', 'cared for' and 'liked' with sessions in which the client felt 'confused', categorised' and 'criticised'. Moreover, the principal dimension contrasts sessions which involved much therapist 'direction' and feedback' and sessions in which the client's 'views were accepted' with sessions in which the 'therapist imposed their views'.

4.4.1.5 PCA plot

Figure 4 shows the plot derived from principal component analysis of the average grid of the whole group. The plot demonstrates how participants construe different elements (therapy sessions) in construct space. Specifically, constructions of the sessions which can all be categorised as positive sessions (i.e. best, ideal, feel good, helpful) included being understood by the therapist, feeling safe in the therapy, feeling cared for and liked by the therapist, and having one's views accepted. In contrast, participants construed 'worst session', 'ineffective session', and 'damaging session' in a similar way. The constructions associated with these sessions, which can all be categorised as negative sessions, included feeling categorised, feeling confused, receiving criticism from the therapist, and imposition of views by the therapist. The constructions of receiving feedback from the therapist and the therapist giving direction in the therapy were also both related to therapy sessions experienced favourably.

FIGURE 4

Plot of the elements in construct space for average grid for all participants



4.4.2 Analysis of average grids for clients with different 'personal styles'

4.4.2.1 Comparing average grids for different 'personal styles'

Average grids were constructed for inner- and outer-directed participants and single grid Slater analyses were carried out on these average grids. Perhaps surprisingly, the single grid analyses revealed very few differences in the way participants with different 'personal styles' construed their therapy experience. The only notable difference observed between the group was that 'confused-not confused' appeared to be a super-ordinate construct for outer-directed participants but not for inner-directed participants. Also, the percentage of the total sum of squares for the construct 'confused-not confused' was higher for outer-directed participants compared to other constructs, indicating that this construct was particularly important for outer-directed participants.

4.4.2.2 Grid of Differential Changes

IDIOGRID created a Grid of Differential Changes when comparing the average grids of inner- and outer-directed participants. The two average grids were first centred about their respective construct means, and the second centred grid (outer-directed) was then subtracted from the first centred grid (inner-directed). The Slater analysis measure of salience was then examined on the resulting Grid of Differential Changes in order to see which elements and constructs were most different between the groups. Table 20 shows that the inner- and outer-directed groups differed most in their construing of 'helpful therapy session' and 'damaging therapy session'. This difference was indicated by the higher percentage of the total sum of squares for these elements.

TABLE 20

Differential Changes Grid percentage total sum of squares of elements (N=22)

Element	Sum of squares	Percent total of sum of squares
Helpful session	6.51	29.77

Damaging session	3.29	15.04

Table 21 shows that the constructs the two groups differed on most were those concerning 'views imposed', 'criticised', 'categorised' and 'feedback'. This difference was indicated by the higher percentage of the total sum of squares for these constructs on the Differential Changes Grid.

TABLE 21

Differential Changes Grid percentage total sum of squares of constructs (N=22)

Construct	Sum of squares	Percent total of sum of squares
Views imposed	3.16	14.45
Criticised	2.60	11.90
Categorised	2.30	10.54
Feedback	2.11	9.67

4.5 Case study 1

4.5.1 Jill

Jill was a 40 year old female participant who was approached to take part in the study via a mental health charity. Jill was referred for psychotherapy for her difficulties with depression and had undertaken a 12 session course of CBT 3 years prior to participation in the study. On the questionnaire, Jill rated her experience of therapy as 2 out of 10, indicating an 'extremely negative' outcome. Jill had an inner-directed 'personal style', scoring 20 out of 28 on the DIQ. At the time of completing the research interview Jill was working in the NHS as a support worker. Jill opted for me to go through the questionnaires and repertory grid with her rather than complete them independently.

4.5.2 Jill's grid

Table 22 shows the grid ratings Jill provided for each of the elements on the constructs during her repertory grid interview. The emergent pole is on the left hand side of the construct and has a score of 7 while the implicit pole (the right one of the pair) has a score of 1. As shown in Table 22, Jill's grid scores suggest that 'trust', feeling 'safe', feeling 'understood' and not feeling 'categorised' were some of the important construct poles relating to positive therapy sessions. Since Jill rated her overall experience of CBT as negative it is possible that she did not experience her therapy in these ways. Jill's ratings for the construct 'challenging' show subtle differences between therapy sessions. Jill viewed 'ineffective', 'worst' or 'damaging' therapy sessions as 'not challenging'. In contrast, Jill viewed 'helpful' sessions as 'challenging' and assigned a rating of 7 on the 'challenging' construct for an 'ideal therapy session'. This perhaps indicates that Jill did not find her therapy challenging enough and that this may have contributed to her overall negative therapy experience. Jill's ratings for the construct 'criticised' also varied across therapy sessions. Her responses indicated that 'feeling criticised' by the therapist was not aversive until that criticism was perceived as extreme, as indicated by her rating of 7 on this construct for 'damaging' session.

Jill did not see 'confused-not confused' as a meaningful construct, assigning each session a mid-point rating of 4. The exception to this was that Jill assigned damaging session a rating of 6 on the 'confused-not confused' construct indicating that if therapy involved extreme feelings of confusion then the result was an aversive experience. Similarly Jill assigned mid-point ratings for the construct 'liked by therapist-disliked by therapist' for all elements except for damaging session. Jill's rating of 1 on this construct indicates that her perception that her therapist 'disliked' her may have contributed to a negative therapy experience.

Jill's ratings on the construct 'therapist direction' suggest that too much therapist direction contributed to her negative therapy experience. This would be consistent with research on 'personal styles', which would predict that inner-directed individuals would prefer therapy sessions with less direction from the therapist. However, Jill's

scores also showed that a lack of therapist feedback was associated with a negative experience, which was perhaps surprising as research on 'personal styles' would have predicted that a lack of therapist feedback would be construed positively by inner-directed individuals.

TABLE 22

Jill's repertory grid

ELEMENTS								CONSTRUCTS	
	BEST	WORST	IDEAL	INEFFECTIVE	HELPFUL	DAMAGING	FEEL GOOD	Construct (Emergent Pole) 7	Contrast (Implicit pole) 4 1
1	6	4	7	2	4	1	6	Understood	Misunderstood
2	5	4	5	2	4	2	5	Views accepted	Views Rejected
3	4	1	7	2	5	1	5	Challenging	Not challenging
4	4	5	3	7	2	6	4	Views imposed	Views not imposed
5	4	4	4	4	4	6	4	Confused	Not confused
6	6	1	7	2	6	4	7	Safe	Unsafe
7	6	2	7	4	6	4	6	Ethical therapist	Unethical therapist
8	6	2	7	3	5	1	6	Real human being	Not real human being
9	4	1	4	4	4	1	4	Liked by	Disliked by
10	4	5		5	2	7	2	Therapist direction	No therapist direction
11	4	1	6	4	5	1	5	Cared for	Not cared for
12	2	1	4	6	3	7	3	Child	Adult
13	3	6	2	4	3	7	3	Categorised	Not categorised
14	5	5	3	3	3	7	2	Criticised	Not criticised
15	6	1	7	2	5	1	6	Trust	Mistrust
16	5	4	5	1	5	1	5	Therapist feedback	No therapist feedback

4.5.3 Slater analyses of Jill's grid

4.5.3.1 Distances between elements

The distances between elements, as presented in Table 23, show that Jill's construing of 'best therapy session' was similar to her construing of 'helpful therapy session' and 'feel good therapy session'. Since Jill rated her experience of therapy as extremely negative, it is unsurprising that there was a large difference between Jill's construing of the elements 'ideal therapy session' and 'damaging therapy session'.

TABLE 23

Standardised Euclidean Element Distances for Jill

Measure	Distances
Distance best session/helpful session	0.45
Distance best session/feel good session	0.40
Distance ideal/damaging session	1.55

4.5.3.2 Measure of salience: Sum of squares

The percentage of the total of sum of squares, presented in Table 24, is higher for 'damaging therapy session', 'worst therapy session' and 'ineffective therapy session'. This indicates that Jill's construing of therapy is more elaborated for negative therapy sessions, which is understandable given that Jill rated her experience of therapy as extremely negative.

TABLE 24

Jill's percentage total sum of squares of elements

Element	Sum of squares	Percent total of sum of squares
Damaging session	107.31	29.25
Worst session	74.31	15.04
Ideal session	62.45	17.02
Ineffective session	50.31	13.71

Feel good session	30.88	8.42
Helpful session	21.31	5.81
Best session	20.31	5.54

The percentage of the total of sum of squares, presented in Table 25, is higher for the constructs 'trust-mistrust', 'safe-unsafe' and 'challenging-not challenging'. This is consistent with the findings from the average grid of all participants which revealed 'trust-mistrust' and 'safe-unsafe' were the most meaningful constructs for most participants. However it seems that the 'challenging' construct was particularly important for Jill in her construing of therapy.

TABLE 25

Jill's percentage total sum of squares of constructs

Construct	Sum of squares	Percent total of sum of squares
Trust	40.00	10.90
Safe	38.86	10.59
Challenging	31.71	8.64

4.5.3.3 Variance accounted for by the first principal component

Table 26 shows the variance accounted for by the first principal component. The relatively high percentage accounted for by Jill's second principal component, when compared to that of the whole group of participants, is suggestive of loose construing. This is indicative of her construct system being cognitively complex.

TABLE 26

Percentage variance accounted for by component 1 and 2 for Jill

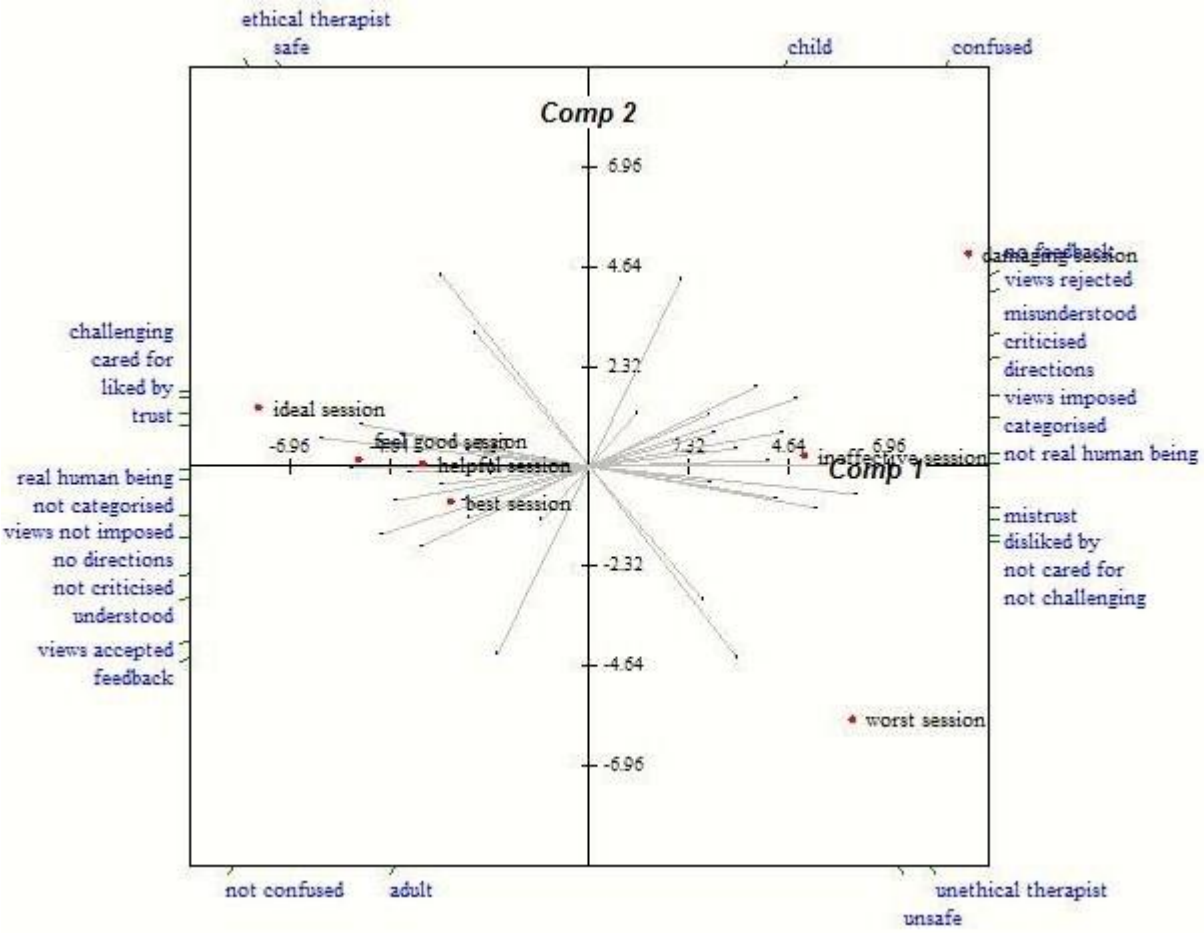
Principal Component	Percentage variance
1	68.73
2	16.72

4.5.3.4 PCA plot

Jill's principal component analysis plot is shown in Figure 5. The construct poles relevant for Jill's 'worst therapy session' were 'unsafe' and 'unethical therapist'. The constructs relevant for a 'damaging therapy session' included those concerning feeling 'criticised', 'misunderstood', 'views rejected', too much 'therapist direction' and too little 'therapist feedback'.

FIGURE 5

Plot of the elements in construct space for Jill's grid



4.6 Case study 2

4.6.1 John

Jill was a 56 year old male participant who was approached to take part in the study via a mental health charity. John was referred for psychotherapy for his difficulties with recurrent depression and anxiety. John had undertaken a 40 session course of CBT 1 year prior to participation in the study. On the questionnaire, John rated his experience of therapy as 9 out of 10, indicating an 'extremely positive' outcome. John had an outer-directed 'personal style', scoring 8 out of 28 on the DIQ. John also opted for me to go through the questionnaires and repertory grid with him rather than complete them independently.

4.6.2 John's grid

Table 27 shows the grid ratings John provided for each of the elements on the constructs during his repertory grid interview. The emergent pole is on the left hand side of the construct and has a score of 7 while the implicit pole (the right one of the pair) has a score of 1. As shown in Table 27, John's grid scores suggest that feeling 'understood', 'having views accepted', feeling 'liked by', feeling 'cared for', 'trust', 'challenging', 'not feeling categorised', and 'not feeling criticised' were some of the important constructs relating to his positive experience of therapy. John's ratings for the construct 'views of therapist imposed' show subtle differences between therapy sessions. Overall John construed the therapist imposing their views as a negative factor but he also indicated that an 'ideal therapy session' would involve some imposition of therapist views. John viewed therapist feedback' and therapist direction as important, which is consistent with his positive experience of CBT, since CBT is classed as a more directive therapy. The constructs 'child-adult' and 'confused-not confused' were mostly assigned midpoint ratings, indicating that John did not view these as particularly meaningful in his construing of therapy.

TABLE 27

John's repertory grid

ELEMENTS								CONSTRUCTS	
	BEST	WORST	IDEAL	INEFFECTIVE	HELPFUL	DAMAGING	FEEL GOOD	Construct (Emergent Pole) 7	Contrast (Implicit pole) 4 1
1	7	2	7	4	7	1	7	Understood	Misunderstood
2	5	3	5	4	6	1	6	Views accepted	Views Rejected
3	6	2	5	1	4	4	4	Challenging	Not challenging
4	4	6	5	4	2	4	2	Views imposed	Views not imposed
5	4	6	3	3	3	4	3	Confused	Not confused
6	6	4	5	6	6	4	6	Safe	Unsafe
7	6	4	7	6	6	4	6	Ethical therapist	Unethical therapist
8	6	3	7	6	6	4	6	Real human being	Not real human being
9	6	2	6	4	6	4	6	Liked by	Disliked by
10	5	4	5	3	4	4	4	Therapist direction	No therapist direction
11	6	1	6	4	6	4	6	Cared for	Not cared for
12	4	4	4	4	4	4	4	Child	Adult
13	4	6	3	6	2	4	2	Categorised	Not categorised
14	3	5	1	4	1	4	1	Criticised	Not criticised
15	6	3	7	3	6	4	6	Trust	Mistrust
16	4	3	5	3	6	4	6	Therapist feedback	No therapist feedback

4.6.3 Slater analyses of John's grid

4.6.3.1 Distances between elements

The distances between elements, as presented in Table 28, show that John's construing of 'helpful therapy session' was similar to his construing of 'ideal therapy session' and different to his construing of 'worst therapy session'. In contrast to the analyses for the whole group of participants, John did not construe many sessions as very similar or very different. John rated his experience of therapy as extremely positive so it is perhaps understandable that his construing of the 'helpful therapy session' and 'ideal therapy session' was very similar.

TABLE 28

Standardised Euclidean Element Distances for John

Measure	Distances
Distance helpful session/ideal session	0.49
Distance helpful session/worst session	1.51

4.6.3.2 Measure of salience: Sum of squares

The percentage of the total of sum of squares, presented in Table 29, is higher for 'damaging therapy session' and 'worst therapy session'. Consistent with the findings for the whole group of participant, this indicates that John's construing of therapy was more elaborated for negative therapy sessions. This is surprising considering John rated his experience of therapy as extremely positive.

TABLE 29

John's percentage total sum of squares of elements

Element	Sum of squares	Percent total of sum of squares
Worst session	71.33	31.60
Damaging session	37.33	16.54
Ideal session	25.18	11.16

Helpful session	24.90	11.03
Feel good session	24.90	11.03
Ineffective session	24.04	10.65
Best session	18.04	7.99

The percentage of the total of sum of squares, presented in Table 30, is highest for the construct concerning feeling 'understood'. This is consistent with the findings from the average grid of all participants which revealed feeling 'understood-misunderstood' was a super-ordinate construct for participants. Other meaningful constructs for John included those concerning feeling 'cared for' and having 'views accepted'.

TABLE 30

John's percentage total sum of squares of constructs

Construct	Sum of squares	Percent total of sum of squares
Understood	42.00	18.61
Cared for	21.43	9.49
Views accepted	19.43	8.61

4.6.3.3 Variance accounted for by the first principal component

Table 31 shows the variance accounted for by the first principal component. The relatively low percentage accounted for by John's second principal component is suggestive of tight construing. This is indicative of his construct system being more uni-dimensional.

TABLE 31

Percentage variance accounted for by component 1 and 2 for John

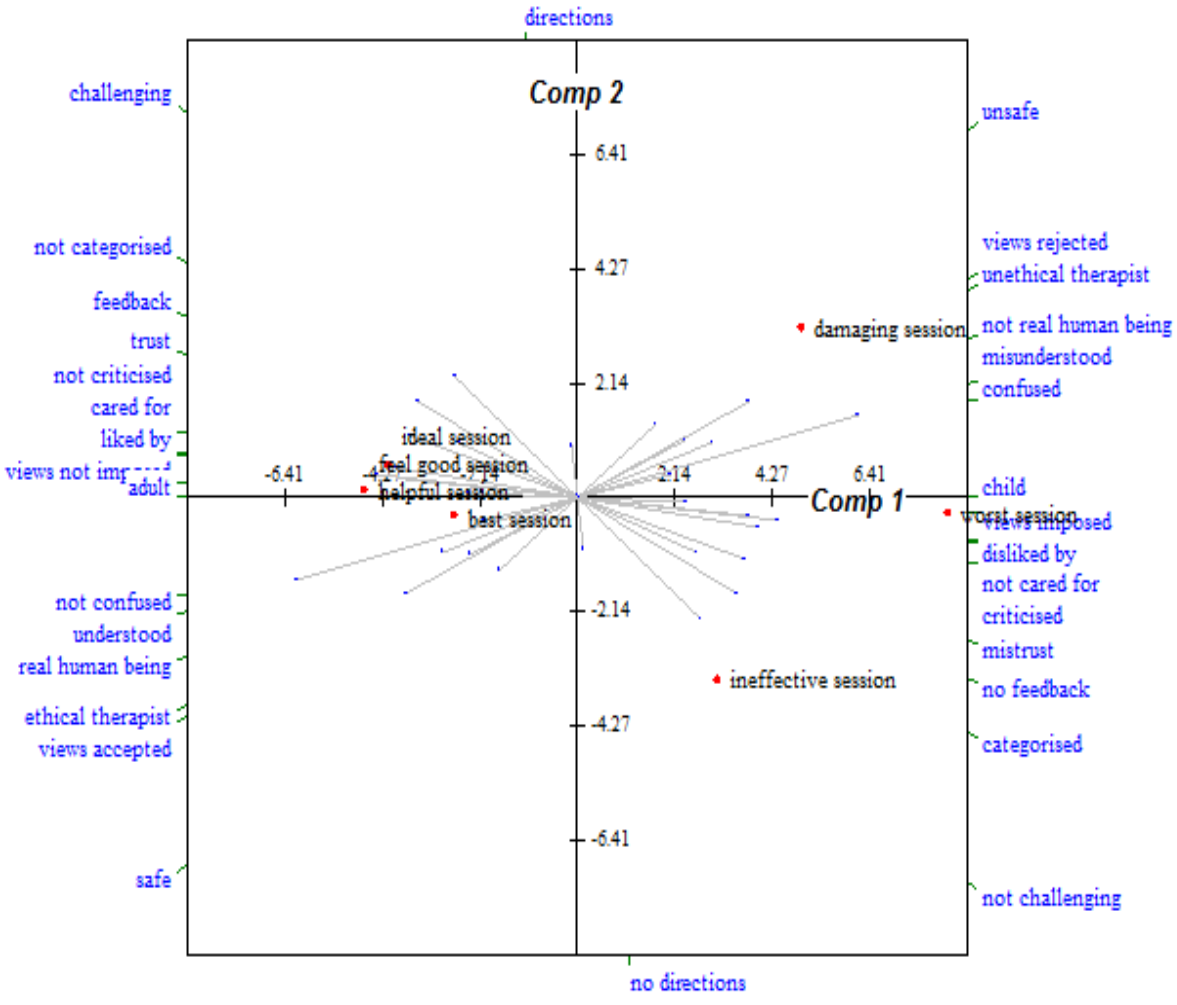
Principal Component	Percentage variance
1	74.18
2	9.84

4.6.3.4 PCA plot

John's principal component analysis plot is shown in Figure 6. John's construing of a 'helpful therapy session' was very similar to an 'ideal therapy session'. The construct poles John associated with a 'helpful therapy session' included feeling 'liked by', 'cared for' and 'not criticised' by the therapist.

FIGURE 6

Plot of the elements in construct space for John's grid



Discussion

The overall aim in the present study was to improve understanding about experiences of psychotherapy from the perspective of the client. Whereas most of the previous research has focused on the relationship between 'personal style' (of client or therapist) and preferences for therapeutic orientation this study represents an attempt to examine whether the combination between theoretical orientation and 'personal style' has an effect on therapeutic outcome. It is also one of the first studies to use repertory grids to explore factors which make a positive or negative therapeutic outcome more or less likely. The Discussion section is separated into 3 sections. The first section presents the main findings of this study, in response to the research questions, and discusses the meaning of these findings in relation to previous research and theory. The second section assesses the strengths and limitations of the study in order to see whether the interpretations brought to the study are supported. The third section considers the clinical implications of this study's findings and outlines potential areas for future research in light of these findings.

5.1 Study findings

5.1.1 Primary hypotheses

This study found that the fit between an individual's 'personal style' and the type of therapeutic approach they received was predictive of either positive or negative outcome. A significantly greater number of inner-directed clients had a negative experience of more directive therapy approaches compared to outer-directed clients, who were more likely to have had a positive experience. Moreover, inner-directed clients were more likely to have a positive experience of less directive therapy. These findings support the primary hypotheses and are consistent with existing research which showed that both therapists and clients are likely to prefer therapeutic approaches consistent with their 'personal style'. However, whilst a variety of research studies have demonstrated that the 'personal style' of an individual (client or therapist) influences their *preference* for selecting a certain type of therapeutic

approach, the current study indicates that this fit between 'personal style' and therapeutic approach actually has a significant effect on the overall *outcome* of therapy.

In a summary of research on the impact of 'personal styles' on preferences for therapeutic approaches, Winter (2008) proposed that inner-directed individuals are more likely to prefer therapies with a less directive focus whereas outer-directed individuals are more likely to prefer more directive, structured approaches such as cognitive-behaviour therapy. The current research supports this proposal and adds to the growing alternative evidence base which argues that 'personal style' should be considered when matching clients with psychological treatment approaches. This research adds to evidence emphasising the importance of 'personal styles' in psychological treatment selection and its relevance is potentially far reaching within the field of psychotherapy outcome research. As discussed previously, the ever-growing pressure for therapies to prove that they are evidence based has overshadowed research enquiry into possible adverse effects. This research provides evidence that a dissonance between an individual's direction of interest and the epistemological stance inherent in a therapeutic approach can contribute to a negative therapy experience. Arthur (2000) suggested that a mismatch between client and therapist 'personal style' and the epistemology underlying a therapeutic approach could result in dissatisfaction. The findings in the present study support Arthur's assertion as inner-directed clients were more likely to have a negative experience of directive therapy.

5.1.2 Secondary hypotheses

Analysis of repertory grid data was conducted to investigate specific secondary hypotheses. In particular, these hypotheses explored similarities and differences in the way clients with different 'personal styles' construe therapy. However, analysis of the repertory grids revealed more similarities in construing between clients with different 'personal styles' than differences and most of the secondary hypotheses were not supported.

The hypothesis which predicted that loose construing would be associated with a more negative outcome in directive therapies was however supported. Although this finding was consistent with previous research (Winter et al. 2006) it was not supported by the secondary hypothesis which predicted that there would be an association between 'personal style' and tightness of construing. Thus, although there was a significant relationship between loose construing and outcome in directive therapies, this relationship was not, as predicted, accounted for by outer-directedness.

It is possible that there was high commonality in the construing between participants with different 'personal styles' because of the design of the repertory grid. The grid analyses revealed that participants construed particular therapy sessions in a very similar way. Specifically, the positive therapy sessions (best, ideal, helpful, feel good) were construed very similarly as were the negative sessions (worst, ineffective, damaging). Therefore the tight construing of most participants (as shown by the low percentage of variance accounted for by the second principal component) may have been because of a lack of differentiation in the meaning of elements (therapy sessions) rather than being indicative of a participant construing therapy in a rigid, uncomplicated way. Whatever the reason, the results did not support previous research in demonstrating a link between tightness of construing and 'personal style'.

The remaining secondary hypotheses predicted that individuals with different 'personal styles' would have a different experience of 'therapist direction' and 'therapist feedback' as measured by these constructs on the repertory grids. However comparison of mean ratings on these constructs for an 'ideal therapy session' revealed no difference between participants with different 'personal styles'. The ratings showed that the majority of participants would ideally like some 'therapist feedback' and some 'therapist direction'. These findings did not therefore help to explain why the combination between 'personal style' and therapeutic approach had a significant effect on therapeutic outcome.

IDIOGRID was used to create average grids for participants with different 'personal styles' with the aim of identifying differences in construing between the groups which could usefully inform the findings from the primary hypotheses. However, the only

notable finding when comparing the average grids was that confusion was considered to be particularly meaningful for outer-directed participants but not for inner-directed participants. Previous research on 'personal styles' might explain this difference in terms of inner-directedness involving greater flexibility in construing and therefore greater toleration of confusion. However, to draw this conclusion would be slightly tenuous given that the similarities in construing between clients with different 'personal styles' far outweighed the differences and that measures of cognitive flexibility (tightness) revealed no significant differences.

A Grid of Differential Changes was created to examine which constructs were construed most differently by the groups. This analysis showed that the constructs the two groups differed on most were those concerning 'views imposed', 'criticised', 'categorised' and 'feedback'. It is possible that differences on these particular constructs may contribute to the differences in therapeutic outcome between participants with contrasting 'personal styles'. Previous research indicates that the components which distinguish more directive therapies from less directive therapies[10] are likely to be better suited to outer-directed individuals. If 'personal style' significantly relates to outcome with different types of therapy, and this study shows that it does, then it is consistent that individuals with contrasting 'personal style' would construe the component factors which distinguish between these therapy types differently. This was further supported by comparison of the individual case examples, which showed that the outer-directed participant was more likely to prefer the therapist 'imposing views'.

5.1.3 Grid analyses and helpful aspects of therapy

Although it was not the main aim of this study, the results add to the research literature on causes of effects in psychotherapy. As indicated in the Introduction, there has been a relative lack of research examining factors that contribute to a

[10] Directive therapies are more likely to involve greater direction by the therapist in terms of the extent to which they assert their view, suggest therapeutic activities and offer feedback.

negative therapy experience. The analysis of the average grid for all participants offers some useful pointers regarding which aspects of therapy can be considered to be unhelpful. The constructs associated with negative therapy sessions included feeling categorised, feeling confused, receiving criticism from the therapist, imposition of views by the therapist, feeling unsafe, feeling misunderstood, feeling disliked by the therapist, feeling uncared for by the therapist, and having views rejected. Whilst many of these constructs appear to be common sense, it is worthwhile reiterating their importance since the drive to determine the specific ingredients for 'gold standard' EBP should not come at the expense of neglecting some of the fundamental factors necessary for avoiding an aversive experience.

5.1.4 Grid analyses and PCT model of helpful and unhelpful aspects of therapy

The repertory grid analyses in this study supported Winter's proposal that invalidation of an individual's constructs during therapy contributes to negative effects. Winter suggested that a positive therapy experience involved some invalidation of a client's constructs within an overall climate of validation. The analysis of the average grid for all participants supported this proposal as feeling 'understood' by the therapist and having one's 'views accepted' were important constructs relating to positive therapy sessions. Winter's PCT model indicated that unhelpful events in therapy involved either persistent invalidation of constructs or conversely total validation of constructs. Analysis of the average grid for all participants supported the idea that persistent invalidation of constructs would be unhelpful. Specifically, therapist 'imposing views' and 'feeling criticised' (by the therapist) were both construed as negative aspects of therapy. Support for the notion that unhelpful events in therapy involved total validation of constructs was less clear. If total validation of constructs is associated with unhelpful events then one might have perhaps expected the 'challenging' construct to have been associated with positive therapy sessions. However, the average grid analysis showed that the construct 'challenging' did not relate to either positive or negative sessions. Case study examples showed that the extent to which therapy was challenging was an important determinant in the overall

experience of the therapy. In particular, if therapy was construed as either too challenging or not challenging enough then it was likely to be associated with a negative experience.

5.2 Strengths and limitations of the study

There were a number of strengths and limitations in this study which may influence the credence given to its findings.

5.2.1 Sample size

Although less than the statistical power analysis estimate, the final sample size of 30 was deemed adequate enough to complete the proposed data analyses. A larger sample size would allow for greater sensitivity when evaluating the significance of the findings and so any interpretations of the findings should be treated with caution.

5.2.2 External validity

An important aspect of assessing a study is to consider its *external validity*; that is the extent that the study's findings can be generalised beyond its immediate context (Barker, Pistrang & Elliott, 2002). The question of external validity is concerned with the representativeness of the study with regard to the characteristics of the sample, procedure and setting. This study had good external validity meaning that the findings could be generalised from the sample to other clients of similar gender, ethnicity and problem type who have received particular psychotherapies.

5.2.2.1 Gender, ethnicity and age

The sample comprised an equal gender distribution and a broad range in the ages of the participants. This meant that any findings can be generalised to both males and

females and to clients of various ages. Only one participant was of an ethnicity other than white British so the findings can only be generalised to white British clients. No specific effects of age, gender or ethnicity emerged.

5.2.2.2 Context

Participants in this study were mainly recruited from mental health charities although a small minority of participants were recruited from within the NHS. The majority of participants recruited from charities had previously been treated (and discharged) from the NHS so were arguably further on in their recovery journey than those clients still within the NHS. This does not necessarily mean that the study's findings can only be generalised to clients involved in non-NHS settings or to clients at a particular stage in recovery. Rather it indicates that clients recruited through charities have had more time to reflect on their experiences in therapy and are perhaps more inclined to discuss these experiences than clients whose mental health difficulties are deemed severe enough to require the continued input of specialist treatment services. Similarly, many of the clients had accessed psychotherapy privately and so any generalisations regarding the context in which therapy was provided should be treated with caution.

5.2.2.3 Problem type and severity

The sample comprised clients with a diagnosis of either depression, anxiety or both. There were also seven participants with an additional diagnosis of personality disorder. Specifying psychiatric disorders in the inclusion criteria reduced the degree of extraneous variability in the sample, making it more possible to detect the effects being hypothesised. However, improving the homogeneity of the sample came at the expense of reducing generalisability of the findings to clients receiving therapy for other psychological difficulties than those specified. Whilst it was possible to collect data on the type of psychological difficulties that the client received therapy for, it was not possible to gather information pertaining to the severity of the client's difficulties. This information can perhaps be inferred by looking at the number of sessions the

client received - with greater number of sessions indicative of more severe difficulties - but this would be guesswork. Since there was no information for any participants regarding the severity of their psychological difficulty it is not possible to comment on how this variable may have influenced the results.

5.2.2.4 Self-selection bias

Although the study overall can be considered to have reasonable external validity, one possible source of bias was that of self-selection to the study. In particular, only two participants rated their experience of therapy as 'average', suggesting that clients who have had either a 'positive' or 'negative' experience of therapy are more likely to want to take part in the study. It is possible that clients who have had an 'average' experience of therapy were under represented in this study because their experience was less meaningful to them so they were less motivated to share their experience. Alternatively, it is possible that there was not a self-selection bias but that in general, the majority of clients receiving psychotherapy rate their experience as either positive or negative. This is consistent with previous psychotherapeutic outcome research (Bergin, 1966) which showed that recipients of psychotherapy are more likely to have greater variance in their treatment change scores (whether positive or negative) than control group counterparts.

5.2.3 Measures

5.2.3.1 'Personal style'

Various research studies have repeatedly demonstrated the validity of the DIQ as a measure of 'personal style'. It suffices to say that the research evidence supporting the relationship between 'personal style' and therapeutic approach is only as good as the DIQ as a measure in itself. Although this study cannot give a comprehensive evaluation of the reliability and validity of the DIQ, it is necessary to state that this study rests on two fundamental assumptions. Firstly, that direction of interest is a

relevant and important variable in the area of psychological treatment selection and secondly, that the DIQ was considered to be a reliable measure of direction of interest.

As in the previous research, an advantage of using the DIQ in this study was that it provided a dichotomous categorisation of 'personal style' so that participants were grouped as either inner- or outer-directed. This helped with the development of clear testable hypotheses and also simplified subsequent data analyses. However, the categorisation of direction of interest into two groups meant that the analyses might not capture a detailed understanding of how varying levels of direction of interest might affect the results. For example, a participant with a DIQ score of 13 would be categorised as outer-directed whereas a participant with a score of 15 would be categorised as inner-directed. In such an instance, the two participants would have been similar in all their responses on the fourteen questionnaire items with the exception of one response where they would have differed. The correlational analyses enabled a closer examination of how direction of interest might affect the results. With a larger sample size it would have been possible to sub-categorise clients depending on their DIQ score so that clients who had more extreme scores (higher or lower) could be differentiated from clients whose scores were closer to the neutral score of 15. This would perhaps have given a less crude dichotomy. However, only a minority of participants had DIQ scores close to 15 so the overall hypotheses tested were considered to be valid. With a larger sample size it would have been possible to exclude certain DIQ scores (those close to 15) from the analysis without reducing the ability to use statistical tests to evaluate the significance of the findings.

A further consideration when using the DIQ was whether an individual's direction of interest was stable over time or whether life experiences (such as psychotherapy) might lead to an individual changing their directedness. The test-retest reliability data were obtained in the construction of the DIQ by assessing a group of occupational therapy students with the DIQ on two separate occasions. There was a three-month interval between the assessments during which the students had experience in a psychiatric hospital where therapeutic community techniques were applied. The test-retest correlation was 0.84, with a significant shift towards a more inward direction of interest. Although the test-re-test correlation was high indicating high test-retest

reliability, the shift towards a more inward direction of interest means that direction of interest should not necessarily be viewed as a fixed trait.

5.2.3.2 Therapeutic approach

A strength of this study was that it followed previous research in distinguishing between therapies as more or less directive. Rather than specifically evaluating the similarities and differences between *individual* types of therapy, this distinction enabled a comparison between different *classes* of therapies. A reasonable criticism of this broad classification division is that the practice of therapy is likely to vary hugely depending on a variety of factors, not least the characteristics and style of the practising therapist. There are many who would argue that the philosophical stance inherent in a therapeutic approach does not necessarily translate into a particular style of practice (i.e. cognitive behaviour therapists are not necessarily going to be more directive). However, as discussed in the Introduction, there is a substantial body of research demonstrating that not only are different approaches underpinned by contrasting philosophical perspectives but that therapists identify with these perspectives; they do so in their preference of therapeutic approach and in the style by which they choose to practise this approach.

Although the system for classifying therapies in this study was to some extent arbitrary and overly simplistic, it is consistent with previous categorisation systems recognised (and used) by researchers, clinicians and service providers alike. Moreover, whilst there is a growing consensus within the field of psychotherapy (both in research and clinical settings) that practitioners are becoming increasingly eclectic in their approach (Jensen, Bergin & Greaves, 1980; Sharp, 2003) and that it is misguided to classify approaches as being 'more or less' anything, this is not reflected in the national service guidelines which argue that specific approaches are more effective than others.

Given the current dominance of directive therapies in national service guidelines, this study aimed to examine whether an individual's satisfaction with a particular therapy

is affected by the fit between therapeutic orientation (in particular the directiveness of the therapy) and the 'personal style' of the individual. Therefore, consistent with existing research it was necessary to classify therapies as more or less directive. With a larger sample size, more time and more resources it might have been possible to evaluate the hypotheses more specifically across individual therapy approaches. Similarly, a prospective design could include a measure of therapeutic practice so that the classification of therapies as more or less directive would be more valid.

5.2.3.3 Therapeutic outcome

The subjective self-report measure was consistent with the study's over-arching constructivist philosophy for understanding therapeutic effects. It might have been possible to provide criteria to help guide participants completing the numerical rating for therapeutic outcome. However, providing these criteria would have meant imposing an objective view on the meaning of this rating, and so instead broad labels (e.g. extremely negative, extremely positive) were provided at either end of the rating scale. Thus participants decided what criteria they would use to evaluate their experience. This self-report research measure is recommended as one type of evidence for EBP rather than the only source of evidence. Although client retrospective self-report data were the preferred evidence in this study (both the therapeutic outcome measure and the repertory grid measure) it would be misguided to rely uncritically on this type of measure alone as the basis for inferring the causal role of particular aspects of therapy (Barlow, 2010).

Some disadvantages of using a self-report measure include possible biases that might influence the results. For example, the client might forget relevant details of their experience or they might be unduly influenced by how they were feeling at the time of completing the questionnaire. A particular limitation of using a self-report measure in this study was that there was only a single evaluative rating of therapy experience. This could have been improved by using multiple ratings for different aspects of the therapy, in addition to an overall global rating of therapy experience, and by gathering self-report information relating to any behavioural changes in the client's life. As it

was, the study relied on the participants' subjective account of the overall usefulness of therapy. A future study might look to include multiple self-report ratings and objective psychometric questionnaires in its measurement of therapeutic process and outcome. Similarly, a prospective design might include therapist self-report data to measure the therapeutic outcome.

5.2.3.4 Repertory grid

The use of repertory grids was original in research looking at the helpful and unhelpful aspects of psychotherapy. This study used supplied constructs elicited from a focus group and so similarities and differences could be examined between participants depending on their 'personal style' and/or therapeutic outcome. An advantage of using repertory grids was that they enabled comparisons across participants as well as detailed idiographic case examples. The bipolar nature of constructs provided the opportunity to examine specific aspects of therapy sessions in an attempt to improve understanding of the associations being studied.

A possible limitation of the repertory grids was that some of the grid elements were too similar in meaning, as indicated by similarities in participants' construing for these elements. Another consideration concerning the repertory grids is the broader question of whether the tightness of construing measures should indeed be regarded as valid indices of Kelly's concept of 'tightness' (i.e. is the tightness of construing measure equivalent to a lack of differentiation in construing) and if they are, whether it is appropriate to use both a high variance of Component 1 and a low variance of Component 2 as such indices. Recent repertory grid research (e.g. Baldouf, Cron & Grossenbacher, 2010) has however supported the convergent validity of these particular grid measures of the structure of construing and has also used the variance of *both* principal components as measures of 'tightness'.

5.2.4 Recall bias

A retrospective design enabled a large number of clients to be invited to take part in the research study. This was important given the time restraints for data collection and analysis. A consequence of adopting a retrospective design was that there was considerable variance across participants for the length of time elapsed between completion of therapy and participation in the study. Overall, two thirds of participants experienced therapy within a five year period prior to the research interview (approximately a quarter had therapy in the year prior) whilst one third of participants were reflecting on therapy experiences from over five years prior to the study. It is possible that the time elapsed between completion of therapy and participation in the study did not impair the individual's capacity to reflect on (and evaluate) their experience of therapy. If this is so, their evaluation can be considered to be a valid measure of outcome.

However, it is also possible that the time elapsed between completion of therapy and participation in the study did impair the individual's capacity to evaluate their experience of therapy. Research on autobiographical memory indicates a tendency for recall biases in the way people reconstruct memories (Berney & Blane, 1997; Walker, Skowronski & Thompson, 2003). It is possible that life events/circumstances occurring in the years following therapy, and the meaning the individual attributed to the role of therapy in the occurrence of these events/circumstances may have influenced the narrative that an individual constructed regarding the success of that therapy (Belli, 1998; Conway, 1996). This perhaps increases the possibility that an individual's memory of therapy will change as a result of subsequent lived experience and that this reduces the validity of their self-report evaluation of therapeutic outcome.

Conversely, it could be argued that disentangling external factors when attempting to evaluate therapeutic effects is an equally pertinent issue regardless of how much time has elapsed between the therapy and the evaluation of the therapy. A challenge for clinicians and researchers when evaluating the effects of therapy is to attempt to understand which effects can be accounted for by the therapy and which can be accounted for by external factors in the client's life at that particular time. This

challenge remains whether the evaluation takes place one day or a number of years following completion of therapy. Future research might seek to examine more closely how people's personalities and emotional processes help to determine what they recall of their therapy experiences retrospectively.

5.3 Clinical implications and future research

5.3.1 Clinical implications

The findings in this study have a number of clinical implications for psychological treatment selection. Since this study explores therapeutic effects relating to different types of therapy and different styles of personality these implications should be of interest to clients, practitioners and service providers alike.

The main finding that the fit between 'personal style' and therapeutic orientation significantly impacts on outcome adds to a substantial evidence base demonstrating that the 'personal style' of an individual (client and/or therapist) is likely to influence their preference for certain types of therapy. This finding is particularly relevant given the current context in the NHS in which clients seeking support for mental health difficulties will in all likelihood be offered a directive, rationalist therapy regardless of their 'personal style' and preference. In this context of EBP proving what works has become imperative but it should be equally important to consider factors which make a negative experience more likely. A possible next step could be for there to be more research attention given to the alternative evidence base exploring the impact of 'personal style' and therapeutic approach on therapeutic preferences and outcomes. This could be achieved by conducting a bigger study with more resources, more time and more access to services.

A useful implication for the interested clinician not likely to conduct such a study would be to be more aware of the fit between 'personal style' and therapy approach when considering psychological treatment selection. A practical step leading on from this increased awareness might be to use the DIQ during the psychological assessment. Another implication for both clinicians and researchers is that the

analysis of repertory grid constructs (relating to positive and negative therapy sessions) adds to the existing knowledge on effective therapeutic practice whilst also contributing to understanding about potential sources of adverse effects in therapy.

The implications of the study's findings are perhaps of particular relevance for the therapeutic work of clinical psychologists. Clinical psychologists typically draw from different therapeutic orientations in their approach with clients; this is likely to be reflected both in the formulations they develop and the techniques they use. It is arguable that clinical psychologists have more opportunity and flexibility to use an integrative and eclectic approach than other professionals. The specific roles clinical psychologists adopt within multi-disciplinary teams and the expertise they have from their professional training perhaps means that they are particularly well placed to incorporate the current findings into their clinical thinking and practice. Similarly, given that clinical psychologists are trained in a variety of therapeutic orientations, it might also be interesting to explore how they develop and define their own 'personal style' in comparison to other professional groups.

5.3.2 Future research

Potential areas for future research include prospective studies with larger sample sizes. For research studies with greater resources a prospective design would potentially allow for better control of confounding variables so that there would be more confidence that it is the fit between 'personal style' and orientation that impacts on outcome. Such a study would provide the opportunity to collect additional pre-therapy and post-therapy measures of both 'personal style' and therapeutic outcome. Repeating the study in different settings with clients with different disorders would show whether the current findings can be generalised beyond the context of this study. In particular, future research ought to include clients of different ethnicity and clients not recruited through mental health charities. A similar study could include data on the therapist's 'personal style' to see whether this too relates to the therapeutic outcome. Future research could also look to develop a global measure of therapeutic outcome indicating whether the recipients' overall experience was beneficial or not.

Feedback from the participants suggested that the measures used in the current study could be complemented by more qualitative information. This need not be a separate research endeavour but could perhaps be incorporated into future research through use of a mixed methods design.

A more comprehensive study might look to measure actual use of therapy techniques to ascertain the practitioner's fidelity to the model they claim to use. An important consideration with any study differentiating between therapies is that we can only infer from the label of therapeutic orientation what is occurring in the process of therapy. This consideration is arguably greatest for researchers seeking to understand the interplay between different variables in producing therapeutic effects. However, research findings form the basis of best practice guidelines which clinicians must adhere to, and therefore this should also be of interest to practitioners. Consistent with this, future research might seek to explore integrated and combination therapies in order to understand psychotherapy effects within the ever-changing context of 21st century psychological treatment. This would be useful since the research literature on therapeutic effects contains a lack of studies examining the efficacy of combination therapies (Lambert, 1992). A final modification might be to replicate the current study but to specifically compare different types of therapy without classifying them as more or less directive. This would allow a more detailed understanding of how therapeutic orientation and 'personal style' interact to influence therapeutic outcome for particular therapies.

5.4 Conclusions

This study explored the construing of individuals who had experienced psychotherapy. In particular, the fit between 'personal style' and therapeutic orientation was examined to see whether this impacted on therapeutic outcome. The study found that the fit between an individual's 'personal style' and the type of therapeutic approach they received was predictive of a positive or negative outcome. Specifically, a greater number of inner-directed clients had a negative experience of more directive therapy approaches compared to outer-directed clients. Analysis of

repertory grids contributed to research looking at the helpful and unhelpful aspects of psychotherapy. However, there were few differences in the construing of participants with different 'personal styles'. Recommendations for future research included having a larger sample, adopting a prospective design and using additional psychometric measures.

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7. APPENDICES

Appendix 1: Poster Advertising Research (version approved for non-NHS recruitment)

EXPERIENCES OF PSYCHOTHERAPY

WOULD YOU LIKE TO TAKE PART IN A RESEARCH STUDY?

YOUR PARTICIPATION WILL CONTRIBUTE TO RESEARCH TRYING TO FURTHER UNDERSTAND DIFFERENT EXPERIENCES OF PSYCHOTHERAPY.

IF YOU ARE INTERESTED PLEASE TAKE PART A PARTICIPANT INFORMATION SHEET FROM THE PLASTIC WALLET ATTACHED TO THIS ADVERT. THE PARTICIPANT INFORMATION SHEET EXPLAINS THE RESEARCH IN DETAIL AND WHAT PARTICIPATION MIGHT INVOLVE.

IF YOU HAVE ANY QUESTIONS OR QUERIES PLEASE CONTACT ME ON THE FOLLOWING NUMBER OR EMAIL ADDRESS:

TEL: XXXXXXXXXXXX

EMAIL: t.allen2@herts.ac.uk

THANK YOU!

THOMAS ALLEN

TRAINEE CLINICAL PSYCHOLOGIST

Appendix 2: Participant Information Sheet (non-NHS approved version)

INFORMATION FOR POTENTIAL RESEARCH PARTICIPANTS

Study title: Experiences of psychotherapy

Lead researcher: Thomas Allen

You are being invited to take part in a research study which looks at experiences of psychotherapy. However, before you decide whether to take part, I would like you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

What is the purpose of the study?

The aim of the current study is to improve understanding about the different effects of psychotherapy. For some people psychotherapy can be a rewarding and supportive experience whereas for others it can be distressing and unhelpful. This study looks to improve our understanding about what aspects of psychotherapy are helpful or unhelpful for different people. The research forms part of the requirements for my Clinical Psychology training at the University of Hertfordshire. The study will be completed and written up by May 2011.

Why have I been invited?

I have contacted 'Charity Name' for help in recruiting participants for this study. You are being approached as your local service has identified that you may have had psychotherapy in the past. It is hoped that at least 50 participants will take part in the study.

What will happen to me if I take part?

If you agree to take part in the study, you should contact me on the contact details in this form. Alternatively you can contact your local "charity name" team for more information. I would arrange a time to meet with you to ask you questions about your experience of therapy. In particular I would ask you to rate different aspects of therapy and to complete a personality questionnaire. The research interview is likely to last between 30-90 minutes and would take place at either your local charity site or at my work base in St Albans. A £5 gift voucher will be offered as reimbursement of any travel expenses. All information you give will be kept confidential.

Do I have to take part?

It is up to you to decide to take part in the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time without giving a reason. This would not affect the standard of care you receive.

What if I change my mind?

If you decide to take part in the study and later change your mind, you are still free to withdraw until the research is written up, without giving any reason. In this case any data you have contributed will be destroyed. A decision to withdraw at any time, or a decision not to take part, will not affect your involvement in the charity.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. All information which is collected about you during the course of the research will be kept strictly confidential. Your answers to the questionnaires will automatically be placed into a spreadsheet which is secure and confidential and will only be accessed by the researcher.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak with Thomas Allen who will do his best to answer your questions. It is possible that because the questionnaires and interview will ask you to think about experiences of

psychotherapy that they may cause you to feel distressed. If you become distressed at any time appropriate support will be offered to you from Thomas Allen, or after the study from the organisation involved in this study. Additionally, leaflets of services where you can discuss your experiences will be made available. However, previous research has shown that many people find discussing therapy experiences as a positive experience.

What will happen to the results of the study?

The results will be written up as a thesis for the requirements of the University of Hertfordshire's Doctorate in Clinical Psychology. It is also hoped that the study will be written up and published in a psychological journal. No participants will be identifiable in written or published material.

Who has reviewed the study?

The study has been reviewed and passed by the University of Hertfordshire School of Psychology Ethics Committee.

How do I get involved?

If you would like to take part in the study or if you would like some more information then please contact me on either t.allen2@herts.ac.uk or XXXXXXXX. You will be given a copy of this information sheet and a signed consent form to keep. If you decide to take part in the study, you will also be given a de-briefing sheet, describing the study again in case you have any questions afterwards.

Thank you for taking the time to read this information sheet and for considering taking part in this study!

Thomas Allen

Trainee Clinical Psychologist,

University of Hertfordshire

Appendix 3: Participant Information Sheet (NHS approved version)

INFORMATION FOR POTENTIAL RESEARCH PARTICIPANTS

Study title: Experiences of psychotherapy

Lead researcher: Thomas Allen

I would like to invite you to take part in a research study looking at different experiences of psychotherapy. Before you decide I would like you to understand why the research is being done and what it would involve for you. If you decide to take part I will go through the information sheet with you and answer any questions you have. Please take time to read the following information carefully and talk to others about the study if you wish.

What is the purpose of the study?

The aim of the current study is to improve understanding about the different effects of psychotherapy. For some people psychotherapy can be a rewarding and supportive experience whereas for others it can be distressing and unhelpful. This study looks to improve our understanding about what aspects of psychotherapy are helpful or unhelpful for different people. The research forms part of the requirements for my Clinical Psychology training at the University of Hertfordshire. The study will be completed and written up by May 2011.

Why have I been invited?

I have contacted local services within Hertfordshire for help in recruiting participants for this study. You are being approached as your local service has identified that you may have had psychotherapy in the past. It is hoped that at least 50 participants will take part in the study.

Do I have to take part?

It is up to you to decide whether to take part in the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time without giving a reason. This would not affect the standard of care you receive.

What will happen if I take part?

If you decide to take part in the study, you should contact me on the contact details in this form. Alternatively you can contact the team which has informed you about the research. I will arrange to meet with you to ask you questions about your experience of therapy. In particular I would ask you to rate different aspects of therapy and to complete a personality questionnaire. The research interview is likely to last between 30-90 minutes and would take place at either a location convenient for you or at my work base in St Albans. Once you have completed the interview and questionnaires you will be given a de-briefing sheet, describing the study again in case you have any questions afterwards. All information you give will be kept confidential.

What are the possible disadvantages of taking part?

The study seeks to explore different experiences of psychotherapy including negative experiences. Therefore the research interview could potentially involve remembering emotionally painful experiences. Before taking part you might want to consider that participation will involve talking about aspects of therapy that were helpful and/or unhelpful although you do not have to share anything you do not want to. If you

become distressed at any time appropriate support will be offered to you from my-self. Additionally, leaflets of services where you can discuss your experiences will be made available.

What are the possible benefits of taking part?

I cannot guarantee that you will find the research useful but hope that by talking about your psychotherapy you will feel that your experience is being valued and validated. The research also has the potential to be useful in matching people with different types of psychotherapy.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do his best to answer any questions you may have. If you remain unhappy and wish to take the matter further, you can do this via the NHS Patient Advice and Liaison Service (PALS) at Charter House, Parkway, Welwyn Garden City, AL8 6JL (01707 369 999; pals**.**herts@hertspartsft.nhs.uk). If you wish to make a formal complaint, contact the Bedfordshire and Hertfordshire Independent Complaints and Advocacy Service (ICAS) on 0845 456 1082. NHS Direct can advise on complaints (0845 4647).

Expenses

A £5 gift voucher will be offered as reimbursement of any travel expenses.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. All information which is collected about you during the course of the research (e.g. name, address) will be anonymised and kept strictly confidential. Your answers to the questionnaires will automatically be placed into a spreadsheet which is secure and confidential and will only be accessed by the researcher.

What happens if I change my mind about taking part in the study?

If you decide to take part in the study and later change your mind, you are still free to withdraw until the research is written up, without giving a reason. In this case any questionnaire/interview data you have contributed will be destroyed. A decision to withdraw at any time, or a decision not to take part, will not affect your potential care in the NHS.

What will happen to the results of the study?

The results will be written up as a thesis for the requirements of the University of Hertfordshire's Doctorate in Clinical Psychology. It is also hoped that the study will be written up and published in a psychological journal. No participants will be identifiable in written or published material. If you decide to take part in the study, you will be given the option of receiving a summary of the results.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Hertfordshire NHS Research Ethics Committee.

Further information and contact details

Thank you for taking the time to read this information sheet. If you would like to take part in the study or if you would like some more information then please contact me on either:

t.allen2@herts.ac.uk

XXXXX XXX XXX

Thomas Allen
Trainee Clinical Psychologist
University of Hertfordshire.

Appendix 4: Direction of Interest Questionnaire (DIQ)

DIQ

How to answer the questionnaire

Starting on the next page you will find a list of choices. These are arranged in pairs across the page. Please choose one or the other item in each pair as being **true** or **more true** than the other member of the pair. An example is given below. Read the two statements and decide which is more true, on the whole, as far as you are concerned. Then put a tick in the space provided alongside the one you choose.

Example

	Put a tick here ↓	or	Put a tick here ↓	
I would prefer to live in town	_____		_____	I would prefer to live in the country

With some of the pairs of items you may feel that both statements are partly true, or that neither of them is really true. In this case try to choose the one that you feel is more true **on the whole**; if you really cannot make up your mind, leave that question blank. There are no right or wrong answers. It is simply a question of what you yourself prefer. There is no need to spend a lot of time making up your mind: there is no time limit, but quick decisions are usually the best.

Try to make a choice between each pair of items even if it is difficult to decide. Remember, choose the statement that comes nearer to your own views or feelings, and only leave a question blank if you really cannot make up your mind.

	Choose here		
I prefer to see a film with a definite plot	1		I prefer to see a film which leaves a lot to my imagination
I think of myself as realistic	2		I think of myself as idealistic
I tend to get irritated by people who are always arguing about theories	3		I tend to get irritated by people who are only interested in practical problems
In visiting places I am more interested in details than in 'atmosphere'	4		In visiting places I am more interested in 'atmospheres' than in details
I would prefer to attend evening classes about the ideas underlying the various religions	5		I would prefer to attend evening classes about the chemistry of the human body
I get on best with realistic people	6		I get on best with imaginative people
I prefer conversations about the meaning of life	7		I prefer conversations about practical, everyday things or problems
I would like to be known as a person of vision	8		I would like to be known as a person of common sense
If I were a teacher I would prefer to teach engineering or domestic science	9		If I were a teacher I would prefer to teach philosophy
I like a holiday without any definite plan of action	10		I like a well-planned holiday with plenty of alternative activities
I prefer the conventional way of doing things	11		I prefer to invent my own ways of doing things
I usually prefer people who don't worry much about 'fitting in'	12		I usually prefer people who take care to 'fit in'
I prefer to spend a free evening with a book about a person's emotional struggles with himself	13		I prefer to spend a free evening with a book about the rise to power of a successful millionaire
I would prefer to be known as a person who gets things done	14		I would prefer to be known as a person who has original ideas
These questions have been easy to answer	15		These questions have been difficult to answer

Appendix 5: Questionnaire Recording Information on Experience of Therapy

EXPERIENCE OF THERAPY QUESTIONNAIRE

Name: …….

What is your gender? Male [ ] Female [ ]

How old are you? 29 years or below [ ] 30-39 yrs [ ] 40-49 yrs [ ]
50-59 yrs [ ] 60-69 yrs [ ] over 70yrs [ ]

What is your ethnicity? Black African [ ] Indian [ ] White [ ]
Black Caribbean [ ] Pakistani [ ] Mixed [ ]
Black other [ ] Bangladeshi [ ] Other [ ]
Chinese [ ] Asian other [ ]

When was your experience of therapy?……....

What type of therapy did you receive? ……....

How many sessions of therapy did you receive? .....

Rating your experience

For some people psychotherapy can be a rewarding and supportive experience whereas for others it can be distressing and unhelpful.

Please circle one of the three options below to describe your experience of psychotherapy:

Negative **Average** **Positive**

Please rate on the scale below to describe your experience of psychotherapy:

1 2 3 4 5 6 7 8 9 10

(Extremely Negative) **(Average)** **(Extremely Positive)**

Appendix 6: Repertory Grid

Sort	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	7	6	5	4	3	2	1	**********
1	7	2	7	4	7	1	7																UNDERSTOOD / MISUNDERSTOOD
2	5	3	5	4	6	1	6																VIEWS ACCEPTED / VIEWS REJECTED
3	6	2	5	1	4	4	4																CHALLENGING / NOT CHALLENGING
4	4	6	5	4	2	4	2																VIEWS IMPOSED / VIEWS NOT IMPOSED
5	4	6	3	3	3	4	3																CONFUSED / NOT CONFUSED
6	6	4	5	6	6	4	6																SAFE / UNSAFE
7	6	4	7	6	6	4	6																ETHICAL THERAPIST / UNETHICAL THERAPIST
8	6	3	7	6	6	4	6																REAL HUMAN BEING / NOT REAL HUMAN BEING
9	6	2	6	4	6	4	6																LIKED BY / DISLIKED BY
10	5	4	5	3	3	4	4																DIRECTIONS / NO DIRECTIONS
11	6	1	6	4	6	4	6																CARED FOR / NOT CARED FOR
12	4	4	4	4	4	4	4																CHILD / ADULT
13	4	6	3	6	6	2	4	2															CATEGORISED / NOT CATEGORISED
14	3	5	1	4	4	1	4	1															CRITICISED / NOT CRITICISED
15	6	3	7	3	6	4	6																TRUST / MISTRUST
16	4	3	5	3	6	4	6																FEEDBACK / NO FEEDBACK

Appendix 7: Participant Consent Form (non-NHS version)

CONSENT FORM FOR RESEARCH PARTICIPANTS

Project Title: Experiences of psychotherapy

Name of Researcher: Thomas Allen

Name of Participant:.....

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. [ ]

2. I understand that my participation is voluntary and that I am free to withdraw at any time, until the point the research is written up, (approximately May 2011), without giving any reason, without any of my rights being affected. [ ]

3. I have been informed that I have the right to a de-brief following completion of the research study. [ ]

4. I agree to take part in the above study. [ ]

_____	_____	_____
Name of participant	**Date**	**Signature**
_____	_____	_____
Name of Researcher	**Date**	**Signature**

Appendix 8: Debrief Sheet

Debriefing Sheet

You have completed different parts of the study; questionnaires and a repertory grid. The purpose of this was to add to the growing research looking at experiences of psychotherapy, specifically looking at individuals with a diagnosis of either personality disorder, anxiety or depression.

The main aim of completing the repertory grid was to explore the way different individuals viewed their therapy. The 14 item questionnaire looked at the personality style of the participants. The study aimed to see if there is an association between the 'personal style' of participants and their experience of different psychotherapies.

Unfortunately, I cannot give you feedback on your repertory grid, however, if you would like to receive a copy of the report summarizes our findings, please leave your contact information with Thomas Allen (t.allen2@herts.ac.uk)

If you would like your data to be withdrawn up until the study is submitted as a doctoral thesis, you will be given a code which will correspond to your data, which will then be destroyed at your wish.

Thank you once again for your participation in this research. If you have any further questions or concerns please feel free to contact me at t.allen2@herts.ac.uk for more information. If this does not result in your satisfaction, please contact Professor David Winter (Doctorate of Clinical Psychology Course Director, Hertfordshire University) at d.winter@herts.ac.uk.

How do you feel now?

It is possible that by participating in this study, you may feel a bit stirred up and/or emotional. If you feel that you would like to talk to someone about these feelings, you are invited to contact either Thomas Allen or in the first instance someone from your charity.

Whilst everyone feels low in mood or anxious from time to time, if you have been feeling like this for some time and it is affecting your ability to cope with day to day life, you should contact your GP or supervisor and/or seek advice from a professional organisation. Some of these organisations are listed below:

*Contact details were given for: MIND, Viewpoint, Samaritans, Mental Health Helpline

Appendix 9: Ethical Approval Form (University)

Revised (September 2006)

SCHOOL OF PSYCHOLOGY ETHICS COMMITTEE APPROVAL

Student Investigator: Thomas Allen

Title of project: A Personal Construct Psychology perspective on adverse experiences of therapy: Examining the relationship between 'personal styles' and constructions of psychotherapy.

Supervisor: David Winter

Registration Protocol Number: PSY/06/10/TA

The approval for the above research project was granted on 28 June 2010 by the Psychology Ethics Committee under delegated authority from the Ethics Committee of the University of Hertfordshire.

Signed: Kvavilashvili **Date:** 28 June 2010

Professor Lia Kvavilashvili
Chair
Psychology Ethics Committee

STATEMENT OF THE SUPERVISOR:

From my discussions with the above student, as far as I can ascertain, s/he has followed the ethics protocol approved for this project.

Signed (supervisor): .....

Date: 28.6.10

Appendix 10: Ethical Approval Form (NHS)

Hertfordshire Partnership NHS Foundation Trust

Thomas Allen
1 Blandford Road
St Albans
Herts
AL1 4JP

R&D Department
Department of Psychiatry
QEII Hospital
Howlands
Welwyn Garden City
AL7 4HQ

Tel: 01707 369058
Fax: 01707 365168
e-mail tgale@herts.ac.uk

21st September 2010

Dear Thomas

Research Study: A PCP Perspective on adverse experiences of therapy

Thank-you for sending me the documentation for the above study. Following an internal review by our R&D Office, I am pleased to tell you that the study now has R&D approval on behalf of Hertfordshire Partnership NHS Foundation Trust.

Approval is given on the understanding that you will notify the R&D Office of any amendments to the study design, that you will carry out the study as specified in the final version of the protocol, and that you will comply fully with the HPFT R&D Policy. I attach a copy of this document for your records.

Finally, I note that you may be intending to recruit some of your participants via MIND and I should like to point out that these participants would not be not covered by R&D Approval from Hertfordshire Partnership NHS Trust.

With kind regards

Tim M Gale
Manager, Research and Development Department
Visiting Professor, Dept Psychology, UoH

Enc.