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Acknowledgements

During the execution of this MSc I have experienced great support and encouragement from many friends and colleagues. In particular I would like to thank John Mcleod my supervisor for his encouragement and guidance and for sharing some of his immense knowledge with me. I would also like to thank Brian Rodgers for his help with the Enalysist software. Finally I would like to thank all my respondents for generously giving of their time and their willingness to share with me their experiences of evaluation.

Introduction

This dissertation consists of three papers on the subject of evaluating counselling practice: a literature review, a research paper and a reflexive essay.

My interest in this subject area arose from my sceptical nature and my desire to know.

When other counsellors and trainers maintained that research had proved that therapy worked I was not inclined to take their word for it. I needed to convince myself by looking at this research for myself. In my own practice I was very aware of all the other factors that could influence someone's life besides a therapeutic interaction with myself. I wanted to know how effective I was as a therapist.

In the first paper **Outcome Research and it's Relevance to Clinical Practice** the general approach to and issues in outcome research are considered and then ways in which the methodologies and tools developed for this research may be used in clinical practice. Most outcome research is not performed for the benefit of helping counsellors evaluate their own practice and therefore their own approach and views are rarely considered. This fact prompted the research project, which is the subject of the second paper entitled **Evaluation as Part of the Process of Therapy**. This was an original qualitative research study using grounded theory to explore the approach to evaluation taken by Person Centred counsellors. The final paper entitled **How Was It For Me: A Reflection on the Process of Doing an MSc** describes my experiences of doing the MSc, the effect it has had on me personally and the learning I have achieved.

Outcome Research and its Relevance to Clinical Practice: A Literature Review

There is a vast catalogue of research into the effectiveness of psychotherapy.

However it is not clear how relevant this is to clinical practice. In particular how can the methodologies and measures used in this research be applied in a real clinical setting by practicing therapists?

“To date, research has had minimal impact on direct service delivery. However, with increasing pressure from external sources to demonstrate treatment effectiveness, the outcome assessment methods developed for psychotherapy research may find practical application in ongoing evaluation of mental health service delivery. However practitioners and administrators alike have been hesitant to use research tools in practice because they are irrelevant, impractical, or costly” Ogles and Lunnen (1996).

This review will look at outcome research in general and then look at ways in which the methodologies developed for research may be used in clinical practice.

In this review the terms counsellor and therapist/psychotherapist are used interchangeably as are counselling and therapy/psychotherapy.

The Development of Outcome Research

“A fundamental commitment of counselling ... is the well being of the client seeking services in applied settings. The purpose of empirical research is to satisfy the highest aims of ethical practice by exploring and verifying the relationships that exist between variables that affect the well being of clients. Specifically, outcome research in psychotherapy is largely aimed at illuminating the effects of treatment variables ... on client functioning” Lambert, Masters and Ogles (1991), p51.

Summaries of the development and issues in outcome research are provided in Lambert, Masters and Ogles (1991), Lambert and Hill (1994) and McLeod (1994).

One of the earliest attempts to prove the effectiveness of therapy was carried out in the 1930s by Fenichel. This consisted of assessing aspects of client life functioning, which were considered highly important, both before and after psychoanalytic treatment. This study found that one third of clients improved a great deal, one third improved slightly and the remainder either remained the same or deteriorated.

However the problem with this kind of study was that it did not provide an estimate of change that might have occurred in clients simply due to the passage of time without any specific psychotherapy intervention. In 1952 Eysenck wrote a paper challenging the results of the Fenishel study and other similar studies by showing that the spontaneous remission rates in untreated clients were the same.

The article by Eysenck stimulated a change in the design of outcome studies to include a control group, which allowed the effect of therapy to be compared with the naturally occurring change arising in a comparable set of people not receiving therapy. In order to ensure the equivalence of the treatment and control group clients

who are similar in respect of demographic profile and presenting problems are randomly allocated to one or another group. Often the control group are clients on a waiting list. Measurements are taken before treatment after treatment and at follow up. This type of research design is known as a randomised control trial (RCT) and is often regarded as the only valid type of design to measure outcome.

A description of such a study by Arbuckle and Boy published in 1961 is provided in Lambert, Masters and Ogles (1991). This study evaluates the effectiveness of client-centred therapy for counselling high school students with behaviour problems. Three equivalent groups were created which were matched on a large number of characteristics such as age, grade, IQ, teacher's behaviour ratings, proportion of peer group accepting and rejecting them, gender, health, number of siblings, socio-economic status etc. One group was given therapy and released from detention, one group had no therapy and was released from detention whilst the third group had no therapy and suffered detention as normal. Using a number of measures such as actual-self compared to ideal-self, vocational-educational objectives, teacher's behaviour ratings and acceptance by peers the effectiveness of client centred therapy was well demonstrated.

Many hundreds of studies such as this have been done showing the effectiveness of psychotherapy in different settings, with different client problems and using different models of psychotherapy, Bergin and Garfield (1994). However even very well designed studies are not without their problems and some of these are illustrated in McLeod (1994) by considering one such study published by Sloane in 1975. This well regarded study looked at the effectiveness of time limited (average 14 sessions over

four months) behavioural and psychodynamic therapy in a university psychiatric outpatient clinic. The study showed the similar effectiveness of the two therapies compared to no treatment. However the effect on the control group clients of being on a waiting list was not evaluated. This could have had either a positive effect, due to having some attention paid to them during the waiting time or a negative one, due to feeling rejected and angry by being kept waiting. Client change was assessed by expert interviewer, therapist and significant other. The views of the client about the effectiveness of therapy was not sought. The study was carried out in a high status well resourced centre, by a small number of very experienced therapists. This is unlikely to be representative of a normal practice situation nor is it clear that the therapists were truly representative of their orientations. It could perhaps be argued that this study was an investigation into the competence of a small number of psychodynamic and behavioural therapists rather than of the efficacy of psychodynamic and behavioural therapy itself.

This illustrates some of the threats to validity intrinsic to outcome research. These threats can be categorised as either internal which is the existence of alternative or competing hypotheses that would account for the data or external which is the extent to which the findings can be reliably and meaningfully generalised to other situations. Unfortunately increasing the internal validity of a study decreases its external validity. Increasing the internal validity of a study requires that the dependent variables i.e. those not under study, be kept as constant as possible. So for instance the client sample should be as homogeneous as possible. If the study is of depression then people who are depressed but also have other problems should not be included. Similarly, therapists should be as homogeneous as possible. They should be matched

for age, orientation, training etc. But more significantly they should offer treatment in the same way. The use of treatment manuals and close supervision is employed in this case. What is clear here is that increasing internal validity increases confidence in the validity of the findings but in doing so ends up studying a situation that bears little resemblance to clinical practice. Can the results of these studies be applied to the real world?

For instance the use of treatment manuals to standardise practice would seem to fit very uneasily with experiential therapeutic models which emphasis the use of self. They also do not fit well in the real life environments where therapy is practiced. This is especially the case when one considers that the majority of therapists describe themselves as eclectic or integrationist, Bergin and Garfield (1994). It would also seem to be unnecessary when other research is considered that indicates that different models of counselling seem to be equally as effective and that the therapeutic relationship is one of the most significant ingredients in effectiveness.

Clinical Significance

Another issue with regard to the relevance of outcome research to practice is the use of statistical significance where the difference between the group means of the treatment and the control group is subjected to a statistical test to determine if the difference could be attributed to chance. There are two problems with this method of determining success. The first is that group statistical comparisons “are based on the average improvement score for all clients and thus provide no information on the effects of therapy for individual clients in that sample” Jacobson, Follette and Revenstorf (1984). The second is that if a large enough sample is used then only

marginal changes are required in order to provide a statistically significant result even though the post therapy scores may indicate that most of the clients remain disturbed or maladjusted.

Jacobson, Follette and Revenstorf (1984) suggest that for outcome research to be clinically meaningful then change must be practically important. That is, change measures should be based on social validation. For instance they should reflect the extent to which clients have eliminated their presenting problems, improved their everyday functioning or changed in a manner recognisable to significant others. Change measured in this way is described as clinically significant.

An overview of methods for measuring clinically significant change is provided in Hansen and Lambert (1996). In the original method of Jacobson, Follette and Revenstorf (1984) societal norms are established for dysfunctional people (those requiring treatment) and for functional people (those not requiring treatment) on whatever variable or measurement instrument is being used to measure change. By measuring populations of “dysfunctional” and “functional” people two overlapping distributions are obtained. The cut off point is calculated where the probabilities are equal of belonging to either distribution. Clinically significant change is measured when the client has moved across the cut off point from the dysfunctional to the functional range provided the measurement is statistically reliable, that is it has a low probability of being due to statistical error. This method uses a particularly stringent definition for meaningful change and in practice alternative distributions could be used that show a level of performance that is relevant in particular circumstances. For example clients that do or do not need hospitalisation, or more generally, movement

from one dysfunctional distribution to a less dysfunctional one. In this way for any one measure a number of different types of distribution could be used.

In Ogles and Lunnen (1996) alternative ways of defining clinical significance are described. For example a 50% reduction in headache activity in the absence of increased medication could be defined as clinically significant with appropriate client populations. Or clinical significance could be defined with reference to a combination of different outcome measures.

In Hansen and Lambert (1996) a number of commonly used measures are listed with their clinical significance properties. An example is given of applying this concept to the use of the Outcome Questionnaire with clients in clinical practice. Here it is suggested that it can be used to measure a dose response effect. This is done by measuring the client's score after each therapy session until a clinically significant change has been obtained. This illustrates a simplistic view of therapy where it is prescribed like a dose of medicine. It ignores the complexity of the process and for instance says nothing about the longer term effect or whether therapy has been the cause of the change. However there is no doubt that the concept of clinical significance goes some way to making outcome measurement tools practically relevant.

Measurement Instruments

Several studies have undertaken reviews of the measurement instruments used in psychotherapy outcome research. Froyd, Lambert and Froyd (1996) reviewed 334 outcome studies from 21 journals published between 1983 and 1988. A total of 1430 outcome measures were used to assess outcome in these studies. There were a total of

851 different measures of which 278 were unstandardised in that they had no reported validity or reliability figures. An average of 4.36 instruments were used with a range from 1 to 16. The typical instrument is a questionnaire in which the client rates his or her own symptoms including behaviour and feelings. The most commonly used of these were the Beck depression inventory, the state-trait anxiety inventory, the Hamilton rating scale for depression, the symptom checklist 90, the lock wallace marital adjustment scale and the MMPI.

One of the conclusions to draw from this kind of study is that more organisation and standardisation is required in choosing and using outcome measures. It is important to choose a set of measures that give a variety of perspectives on outcome Strupp and Hadley (1977). Also in order to be able to compare the results from different studies it is important to have a small commonly used set of measures. From a clinical practice point of view this kind of chaos means that choosing tools for outcome measurement is very confusing and complicated.

In Lambert, Ogles and Masters (1992) and Lambert, Masters and Ogles (1991) a scheme is proposed to bring order to this chaos. Including a revision by Ogles and Lunnen (1996) this scheme organises outcome measurement instruments into five theoretical dimensions or categories as shown in Table 1.

| Content | Social Level | Source | Technology | Time |
|----------------|----------------------------|--------------------|---------------------------|-------------|
| Cognition | Intrapersonal | Self | Evaluation (global) | Trait |
| Affect | Interpersonal | Therapist | Description (specific) | State |
| Behaviour | Social Role Performance | Trained observer | Observation | |
| | | Relevant other | Status | |
| | | Institutional data | | |

Table 1: Categories of Outcome Measurement

Using this scheme any measurement instrument can be described in terms of an attribute for each of the categories. Each of the categories is explained in detail as follows:

Content: This category describes what aspect of the subject is measured. Their thoughts, feelings or behaviour. Often tools measure more than one of these attributes, however they can be categorised in terms of the degree to which they measure one attribute rather than another.

Social Level: The social level category describes from what perspective the content change is viewed, either within the client themselves, in the client's relationships or in their social functioning. The intrapersonal would include such things as psychopathology, mood, self-concept, self-control, negative cognitions, behavioural deficits and so on The

interpersonal would include such things as marital adjustment scales and sexual performance. Finally social role performance might include adjustment to and motivation at work, or in school and level of delinquency. Although three attributes have been specified in this category it could be considered a continuum that represents the degree to which an instrument measures the intrapersonal versus the interpersonal or social role.

Source: The source category indicates who does the measurement. These attributes range from those closest to the counselling process to those furthest away. The client themselves and the therapist are the most informed sources, being at the centre of the counselling process. Following them are trained observers who are either part of the process or who have been given specific targets to rate that are highly relevant to the treatment process. The next source are relevant others such as spouse, friend, workmate or fellow group member who enter the rating task with an agenda that is quite different from the client, therapist or trained observer. Finally institutional data are obtained from sources not associated with the treatment process at all, such as the use of public records in studies of alcohol and drug addiction.

Technology: The technology category describes how the measurement is done and ranges from the least to the most factual or rigorous. Evaluation is a retrospective global judgement about the effectiveness of counselling, for example a post therapy satisfaction questionnaire completed by the

client. This attribute is regarded as the least rigorous. Description involves actual specification of changes. Typically it involves a pre and post therapy rating of the presence, absence or intensity/frequency of specific symptoms. For example the Beck Depression Inventory (BDI) is a client rated descriptive instrument. Observation is a rating of specific client behaviours by judges, significant others or therapists. For instance the client can be observed before and after therapy attempting to approach a feared object. Status is the most factual or disinterested method and includes physiological measurements such as heart rate or breathing rate as well as client status such as separated or divorced.

Time: The time category describes the extent to which the instrument measures a stable trait like characteristic versus and unstable or state like characteristic. An unstable characteristic would be measured over a short time period such as the past week whereas a stable characteristic would be measured over a long period and be asking a question such as “how are you generally”.

Any outcome measurement instrument can be classified on each of the five dimensions so for instance the BDI is primarily an affective content measure assessing the intrapersonal social level using the client as source. It uses descriptive technology and measures a state-like characteristic.

The scheme as a conceptual framework has some drawbacks. Schacht and Henry (1992) suggest two. The first is that outcome measures should be chosen with reference to the hypothesised therapeutic processes. That there must be congruence between problems, treatments and outcomes and the measures chosen should reflect that congruence. Secondly is the problem of interpreting the outcome data. For instance an increase in depressive symptoms as measured on a scale such as BDI may not always indicate failure. This may be the case if prior to increase in depression the client may have been in denial of some difficult life event. The increase in depression would be indicating progress as a natural reaction to the client accepting the event.

A more comprehensive analysis of the scheme is present by Elliott (1992) who suggests that in order to develop a sound conceptual framework it is first necessary to define what is meant by “outcome”. That the scheme proposed in Lambert, Ogles and Masters (1992) goes some way to doing this but that some of the elements of the model remain implicit and contain inconsistencies. Elliott (1992) suggests a clarification of what is meant by outcome containing the following features:

1. **Client focus** – Must assess some aspect of a client or client system.
2. **Subsequent to treatment** – Must follow some counselling or therapy.
3. **Evaluative** – Must evaluate the client on some standard of function or dysfunction.
4. **Comparative** – Must compare client functioning to some previous baseline.
5. **Perspective** – Must be from a particular point of view.

The most troublesome category in the Lambert scheme is that of technology which seems to include a number of distinct concepts. The distinction between observation and description is not clear but reflects a confusion with source. The technology category includes two different kinds of judgement; global ratings of level of function and ratings of change brought about by treatment. Status includes two very different types of element, physiological and demographic, which may be more meaningful under the content heading. The underlying theme in this category is that in going from evaluation to status one increases the objectivity and therefore validity of the measure Lambert, Masters and Ogles (1991). This is based on a positivist assumption that mechanically obtained “facts” are somehow “purer” and more scientific than judgements. In fact embedded in this category is how directly the measures and evaluative standards map onto one another. Evaluation and description are a direct measure of change whilst observation and status are more indirect.

The time orientation category emphasises the temporary versus permanent aspect of change through the time frames used in describing client functioning. For example “past week” versus “how are you generally”. Elliott points out the other aspects of time that are central to evaluating outcome that should be taken into account. These are “before versus after”, “immediate versus delayed” and “session versus treatment”.

In Lambert, Ogles and Masters (1992) the authors are proposing the organisational scheme as a way to bring order to the area of outcome research. They suggest that using the scheme to categorise different measurement instruments will allow researchers to choose more appropriate sets of measures. For instance researchers may choose instruments that address the same categories in an effort to demonstrate the

reliability of the assessment. Alternatively, with knowledge that client change is complex, they may select assessment methods that come from different categories as a way of ensuring that different aspects of client change are represented. They also suggest that these approaches could be applied to the selection of measures for clinical practice.

In Ogles and Lunnen (1996) ways of using the categorisation scheme for clinical practice are specifically addressed. A number of well validated and commonly used measures are listed. They suggest the use of the scheme for selecting the outcome measures that provide the most useful information about client change. The content area, social level and time orientation of the instrument will be selected depending on the nature of the organisation's interest. So for instance a couple therapy service would be more interested in interpersonal change than an individual therapist who would be likely to be interested in intrapersonal change. A work place counselling service may be more interested in behavioural change than affective or cognitive change. The practical limitations of such things as time, money and client comfort need to be considered and will often place severe limitations on the source and technology characteristics of the instrument chosen. So for instance a post service questionnaire which employs a client report source with an evaluation technology may be the most cost effective way of assessing client satisfaction and perception of change. For some organisations this may outweigh the fact that it may not have a very good response rate, it only reflects the client's perspective and may not reflect pre to post treatment change accurately. Alternatively using a self report source with descriptive technology tool such as BDI or SCL-90 a more accurate assessment of change may be obtained and it is easily administered. However the response rate

might not be 100% because of drop outs, some client's issues may not be reflected in the selected measures and other individual's perceptions of client change are not represented.

The categorisation scheme provides a way of selecting appropriate measures from those already in existence. An alternative approach is to develop a tool specifically for clinical practice, Barkham, Evans and Mellor-Clark (1998). The CORE tool has been developed specifically for the evaluation of outcome in clinical settings with emphasis on ease of use. It has good psychometric properties and clinical significance values are available. It has four different dimensions; well being, problems/symptoms, functioning and risk. It is designed as a basic general evaluation tool that can be supplemented with more specific instruments such as BDI if required.

Outcome Criteria

What criteria are used when judging outcome will depend on the perspective of the judge. For instance the client may have a different set of criteria to the therapist and this may be different again from the client's employer. Strupp and Hadley (1977) explore this issue by considering the differing views of client, therapist and society when evaluating outcome. They illustrate how these views may conflict and suggest that it may be necessary to obtain all three perspectives when measuring outcome. For instance a client may end their marriage after being in therapy and this may be regarded by therapist and client as indication of a positive outcome whilst society in the form of the client's family and perhaps his employers may disagree. They point out that clients may enter therapy not for the purpose of elimination of symptoms but rather to find meaning in their lives. Therefore evaluating therapy outcome from

multiple perspectives should include more than having clients assess the domains of outcome that expert's value.

Some studies have been carried out to determine the client's view of the benefits of therapy. Elliott, Clark and Kemeny (1990) examined the changes identified by ten depressed clients following sixteen sessions of experiential therapy. Each client was given a post treatment interview, which was then analysed using a grounded theory approach by four independent people who then agreed on consensus categories that best represented the changes. The valued changes that were identified were:

- **Improvements within the self:** An increase in positive feelings, such as general mood, optimism and self esteem. An increase in ability to deal with life situations. Closer contact with self in terms of realisations about self and openness to own feelings.
- **Improvements in dealing with others:** Improvements in interpersonal style such as increased independence or assertion and increased openness to or intimacy with others. Improvements in interpersonal perceptions which includes changes in views towards others and changes in other views of the client.
- **Improvements in life situation:** Improved relationship aspects and improved non-relationship aspects.

Strupp and Connolly (1996) asked clients at the end of treatment consisting of up to twenty five sessions of psychodynamic therapy to "describe the most important changes you have experienced". The authors converted each of the answers into a list

of phrases in the original wording that described distinct changes. A range of one to seven changes was reported in this way from the sixty seven clients who took part. Groups of students were then used to rate the semantic similarity of the phrases in order to reduce the list to a more descriptive set. This reduced set was then grouped together into clusters, which were named using a recaptured item technique. The process was validated using various statistical techniques. The aim of the method was presumably to deny or avoid the idea of subjectivity and produce an “objective” result that would represent the “average” person’s view of the data. Given that the authors themselves did the original selection and that there is no such thing as an “average person” one might argue that there is no getting away from subjectivity. The results of this study were as follows:

- **Improved symptoms:** This included greater self control and improved psychological symptoms.
- **Improved self understanding:** This included understanding self better and also an increase in interpersonal openness in terms of being able to express emotions better and communicate needs.
- **Improved self confidence:** This includes such things as more confidence in relationships, more able to take risks and feeling OK to like self.
- **Greater self definition:** This includes greater independence as in being able to put self first and better boundaries as in aware you can’t control others.

Elliott and James (1989) reviewed the research literature in order to evaluate the variety of therapeutic experiences reported by clients.

Clients typically experience to varying degrees such general factors as having been helped, being satisfied with treatment and having improved. At the same time they also have a sense of how they have been helped or in other words the specific positive therapeutic benefits that have occurred. These effects are divided into therapeutic realisations within the scope of treatment or “impacts” and outcomes extending beyond treatment or “outcomes”.

Consideration of “impacts” studies produced the following:

- **Task/problem solving impacts:** self understanding, guidance, self awareness, taking responsibility, insight into others, facing reality and self control.
- **Interpersonal/affective impacts:** expression/catharsis, reassurance/confidence, feeling understood and instillation of hope.

Further the authors reviewed five studies which asked clients to describe specific outcomes of therapy. The most common treatment related changes were:

- **Increased self esteem**
- **Symptom relief**
- **Improved interpersonal relationships**
- **Greater mastery**

The authors point out that psychotherapy outcome researchers have attended primarily to assessments of symptom changes at the expense of other outcomes important to clients. This is reflected by Strupp and Connolly (1996) who state that “Although

current research on the efficacy of psychotherapy often includes multiple domains of outcome assessed from multiple perspectives, constructs such as self-understanding, self-confidence and self-definition are rarely assessed as important domains of outcome”.

In general these studies although using different methodologies, different client groups and different therapeutic approaches come to similar conclusions which are that both changes in self concept and interpersonal problems are regarded as important by clients as well as changes in symptoms.

No studies were found which explored therapist’s views of what criteria should be used for outcome assessment. The categorisation scheme of Lambert, Ogles and Masters (1992) includes a source category which allows for different perspectives on outcome to be included. However the perspective is that of a user of an instrument that has been designed and chosen by someone else. It does not mean that the instrument is measuring what is important to the user. The people designing outcome measures are usually researchers, psychologists and other “experts” who are likely not to represent the views of therapists or clients in general.

Client Specific Measures

“Even though current research studies focus on seemingly homogeneous samples of patients (e.g., unipolar depression, agrophobia), it is clear that each patient is unique and brings unique problems to treatment. For example, while the major complaint of a person may be summed up as “depression” and the person may meet diagnostic criteria for major depression, this same patient can have serious interpersonal

problems, somatic concerns, evidence of anxiety, financial difficulties, problems at work, problems parenting children, substance abuse and so on. These diverse problems are often addressed in therapy, such that proper assessment of outcome requires that changes in all these areas be measured to obtain a complete picture of change. The complexity of human behaviour and the complexity of theories and conceptions of human behaviour invite incredible difficulty in operationalising the changes that occur as a result of psychotherapy” Lambert and Hill (1994) p77.

One way of making outcome assessment relevant to clinical practice is to consider single cases. One approach to this is to individualise the outcome measures applied to a case so they reflect the issues of the particular client. That is, to identify the client’s target complaints or presenting problems and their consequent therapeutic objectives or goals.

One description of this approach is given in Nelson (1981) where it is suggested that client problem behaviours and desired therapeutic objectives should be defined with clear behavioural referents. Appropriate goals include changes in the client’s actions, beliefs, verbal responses, feelings or physiological responses. Measurements should be taken regularly throughout the therapy and where possible in the client’s natural rather than therapeutic environment. Different types of measures applicable for the approach are described in this paper including: client self monitoring (client noticing occurrences of their own problem behaviours), client self rating (client quantifying the intensity of a subjective state), card sorts, self report questionnaires, direct observation in the clinic, direct observation in the natural environment, physiological measures and indirect measures (results of the problem behaviour). Although the methods

described have general applicability Nelson appears to have a very behaviourist approach to the problem of outcome assessment. In particular her description of ways of obtaining client compliance with, and accuracy of, self recording appear to have elements of bribery or coercion. These may not be acceptable to some therapists and the accuracy of results obtained in this way would be questionable.

Another method is Goal Attainment Scaling described in Lambert and Hill (1994). Prior to treatment a number of mental health goals are defined. For each goal a scale with a graded series of likely outcomes from least to most favourable is devised. Each goal is weighted to identify its importance. For instance, for the treatment of obesity one goal could be weight loss. A second goal could be the reduction of depressive symptoms, which could be measured by the Beck Depression Inventory.

There are a number of problems with these types of goal setting scheme. There is often high correlation between goals raising questions of independence. Goals judged either too easy or too hard to obtain are often included. Goal attainment is judged on a relative rather than absolute basis so that behaviour change is inevitably confounded with expectation. Setting realistic, useful and measurable goals is not an easy task. Sometimes the client's goals change during therapy and although resetting goals is possible this makes the process even more complicated. Also there is no retrospective consideration of benefit. Clients may consider that therapy has benefited them in ways unrelated to their original goals and they don't become aware of this until after therapy has finished.

Using a psychological assessment tool with a defined clinical significance one can measure whether that particular characteristic has changed for the client. However when considering a single case it is not possible to say whether this was due to the therapy itself or to some external event Schacht and Henry (1992). The same objection also applies to goal setting schemes described above. RCTs get around this problem by using a control group and statistical averaging. If it is assumed that external events are random then they will happen as often in the control group on average as the treatment group thus cancelling the effect.

This issue is addressed in Elliott's Hermeneutic Single Case Efficacy Design, Elliott (2002). In this approach an argument is constructed about the likelihood of any identified change being accounted for by the therapy process. Evidence is considered both for and against therapy being the cause of client change. This approach is justified by comparing it with practical reasoning systems accepted by society for such things as legal rulings and medical decisions.

The method is illustrated by applying it to a particular case. A rich, comprehensive collection of information was made about a client's therapy from different perspectives (client, therapist and researcher). This included quantitative outcome measurements SCL-90 and Inventory of Personal Problems that are given pre and post therapy and Simplified Personal Questionnaire (PQ), which was given after each session. It also included collecting qualitative information from an end of therapy change interview with the client, from the Helpful Aspects of Therapy Form administered after each therapy session, and also records of therapy sessions from therapist's process notes and videotapes.

First the evidence for direct links between therapy and outcome are identified. Elliott suggests that at least two separate pieces of evidence should be obtained supporting the therapy change link before moving on to the next stage of the analysis.

These are such things as:

- *Retrospective attribution*: The client attributes a reported change to therapy without specifying the connection.
- *Process-outcome mapping*: The content of the post therapy changes correspond to specific events, aspects or processes within the therapy.
- *Within therapy process outcome correlation*: The therapist's evaluation of their own performance in the session correlates with changes reported on the PQ questionnaire.
- *Early change in stable problems*: Therapeutic influence can be inferred when therapy coincides with change in long-standing or chronic client problems.
- *Event shift sequences*: A therapy event immediately precedes a stable shift in client problem, particularly if the event and change are logically related. For example therapeutic exploration of an issue followed the next week by change on that issue.

Then a good faith effort is made to find non-therapy processes that could account for an observed or reported client change. This provides indirect evidence connecting change with therapy. Non-therapy explanations for apparent client change are listed as follows:

- *Non improvement*: Changes are trivial or negative.
- *Statistical artefacts*: Things such as measurement error, regression to mean or experiment wise error.
- *Relational artefacts*: Client attempts to please the therapist.
- *Client expectations*: The client's wishful thinking is causing the observed change.
- *Self correction*: Client is doing self help or self limiting tasks to solve problems.
- *Extratherapy life events*: Such things as getting a new relationship or changes in work situation.
- *Psychobiological factors*: For example taking medication.
- *Reactive effects of research*: The fact of taking part in a research project is helpful to the client.

Elliott describes the process of trying to find non-therapy explanations as like detective work with contradictory evidence sought and available evidence weighed carefully. The result is that some non-therapy explanations may be ruled out entirely whilst others may be found to have contributed to the observed change. Both positive and negative evidence should be considered.

The result for the case study presented was that there was good evidence for the view that change was as a result of therapy but that some of the reported change was due to other factors. The outcome of this kind of approach is of a more complex, perhaps real life, picture than that presented by a purely quantitative study, which would tend to give a more one-dimensional yes-no type result. It requires researchers to address

complexities, ambiguities and contradictions that are ignored in traditional RCT type designs.

In this method the client's view of the benefit of therapy is obtained from the end of therapy interview rather than goal setting at the start. This avoids some of the difficulties with goal setting methods but of course is not a measurable quantity. This objection to the validity of the client's post therapy report is accounted for by the nature of the approach, which looks for corroborating evidence.

In this approach it seems that the major source of information comes from the client in their own words. There is some consideration of the therapist's view and none from any external perspective such as family member. The researcher is acting as an independent evaluator.

This complex type of outcome assessment is not possible for a single therapist evaluating their own clinical practice and it may also not be appropriate for evaluating a counselling service with large numbers of clients. It may however pave the way to developing an alternative approach to the more commonly accepted method of only using client self report psychological assessment tools.

Discussion

The types of tools most commonly used for outcome assessment and those considered in detail by the papers reviewed are questionnaires that measure psychological symptoms. Ones such as CORE or BDI have the advantage of being fairly quick and straightforward to use. They have high levels of validity and reliability as tools.

However they have the disadvantage of providing a very narrow and restricted view of outcome. In particular in order to provide a measure of clinical significance an instrument needs to provide quantitative data by using mechanisms such as the likert scale. Collecting data in this way does not allow the respondent, client or therapist, any freedom to give their view of what happened in the therapy. In order to reflect the variety of experience and views of outcome it is suggested that a number of different measures are used. The categorisation scheme of Lambert, Ogles and Masters (1992) can be used to help the selection. However even doing this obtains a very limited perspective when compared to allowing the participants the freedom to describe the experience for themselves.

These tools also concentrate on symptomology. Research into the client's view of outcome indicates that this is only one of the aspects of outcome that is valuable and that changes in self concept are equally as important. Measures are created by researchers, psychologists and other "experts" and based on what they regard as important criteria. Often they reflect a medical model, which approaches practice by treating client's symptoms with doses of medicine. They are unlikely to represent the views of therapists or clients in general.

A critique of client self-report questionnaire measures is given in McLeod (2001) and various problems in their use are indicated. The questionnaires are completed in a social setting that itself changes as a result of therapy, the experience of therapy changes the way that clients make sense of the questionnaire items and the conceptualisation of the person implicit in the questionnaire design is not compatible with that espoused by most contemporary therapeutic approaches. The type of

question that is being asked by this kind of instrument is not what ordinary people, clients or therapists, might be interested in. Such questions as; “what comes out of the experience of therapy”, “in what ways do people change as a result of participating in therapy”, “do people who have received therapy do different things with their lives”.

A further difficulty with this approach is that it provides no information on the cause of any change that happens. Without some indication of cause when considering single cases, which individual practitioners must do when assessing their practice, then it is not possible to say whether therapy was the cause of the change or some external event.

Outcome research has concentrated on proving to society that therapy works in order to validate it as a valuable professional activity. Originally this was to prove its effectiveness in general but latterly it has become more specific in attempting to prove that particular models of therapy work in particular settings and with particular types of client. This has been used to inform health care policy decisions Roth and Fonagy (1996). However this has not necessarily been of much help to therapists in assessing their own practice. Developments such as the CORE system Barkham, Evans and Mellor-Clark (1998) are helpful, particularly for service evaluation. Studies such as Elliott (2002) are helpful when thinking about evaluating single cases. Evaluating counselling as a whole, evaluating particular counselling services and evaluating a single counsellor’s practice are all different activities with different motivations. There is no reason to suppose that the methods and tools of one of these activities are applicable to the others. There is an assumption in the literature Ogles and Lunnen (1996), Lambert, Ogles and Masters (1992) that the methods of outcome research are

applicable to service and practice evaluation. However it is not clear whether therapists are actually making use of any of these developments or even if it fits with what they regard as important for their own practice; what they actually do at the moment when evaluating their own practice. Perhaps as they are the ones delivering the service it would be useful to get their perspective on outcome evaluation.

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Evaluation as Part of the Process of Therapy: A Qualitative Study of How Person Centred Counsellors Evaluate Their Practice

Abstract

The purpose of this study was to explore the approach of Person Centred counsellors to the evaluation of their practice. It was motivated by a concern for what use the tools and methodologies of counselling outcome research were for actual practice. Using open-ended interviews six Person Centred therapists were interviewed in depth about their approach to and experience of evaluation. In particular they were asked to reflect on how they determined whether a particular case was successful or not. The interviews were analysed using Grounded Theory resulting in three main categories. The interviewees all had an awareness of the idea of evaluation and responded to what it meant to them. They had views about the requirements society had for counsellors to evaluate practice and also view about the approach they took for themselves. The process of evaluation required information to be obtained by noting evidence about what were regarded as important aspects of the counselling process. This evidence was then weighed up by a process of analysis and clarification. Evaluation for the interviewees was seen to be a more general process than outcome assessment as carried out by outcome researchers. As well as outcome for the client it includes an assessment of the counselling relationship and reflection on the practice of the counsellor themselves. It is a continuous activity that is embedded in the counselling

process itself rather than being formed from discrete measurements at particular times in the process.

Introduction

Outcome research has concentrated on proving to society that therapy works in order to validate it as a valuable professional activity. Originally this was to prove its effectiveness in general but latterly it has become more specific in attempting to prove that particular models of therapy work in particular settings and with particular types of client. This has been used to inform health care policy decisions Roth and Fonagy (1996). However this has not necessarily been of much help to therapists in assessing their own practice. Evaluating counselling as a whole, evaluating particular counselling services and evaluating a single counsellor's practice are all different activities with different motivations. There is no reason to suppose that the methods and tools of one of these activities are applicable to the others. There is an assumption in the literature Ogles and Lunnen (1996), Lambert, Ogles and Masters (1992) that the methods of outcome research are applicable to service and practice evaluation. However there is little indication as to whether therapists are actually making use of any of these developments or even if it fits with what they regard as important for their own practice; what they actually do at the moment when evaluating their own practice. Perhaps as they are the ones delivering the service it would be useful to get their perspective on outcome evaluation.

There are many tools used in outcome research, which could potentially be useful for practice. Reviews (for example Froyd, Lambert and Froyd (1996)) show that the use of outcome measurement tools is very disorganised but that the typical instrument is a questionnaire in which the client rates his or her own symptoms including behaviour

and feelings both before and after the course of therapy thereby allowing some measure of change to be calculated. Lambert, Ogles and Masters (1992) propose an organisational scheme for categorising outcome instruments. This scheme categorises each tool in terms of what it measures (feelings, thoughts or behaviour), from which perspective (self, relationship or society), who does the measurement (client, therapist, independent expert, records) and how the measurement is done (general improvement questionnaire, specific symptom questionnaire, observation of behaviour, physiological measurement). There are some drawbacks to this scheme. It does not take into account the context of the measurement for instance where an increase in depression could be a positive indication Schacht and Henry (1992). The scheme is also under factored in that there are not enough categories to adequately describe the different aspects of outcome measurement, Elliott (1992). This being the case some of the categories confuse different concepts and Elliott (1992) suggests a alternative categorisation scheme based on a more general definition of the concept of outcome. Ogles and Lunnen (1996) suggest that the categorisation scheme can be used when choosing tools for assessment of practice. They describe the use of this scheme taking into consideration the constraints of real practice such as time and money. An alternative approach is to use a general tool that can be used in any practice situation as described by Barkham, Evans and Mellor-Clark (1998)

The instruments considered in the foregoing tend to concentrate on measuring symptom relief. In any case as they are developed for research or psychological assessment purposes they will tend to reflect the outcome criteria considered important by researchers and psychologists. However, as indicated by Strupp and Hadley (1977) there are other perspectives on outcome that should be considered, in

particular those of the client. Strupp and Connolly (1996) investigated the outcomes of therapy that were considered important by clients. Their findings suggest that as well as improvement in symptoms, clients value improvements in self understanding, improvements in self confidence and improvements in self definition. Their results are generally in line with other studies that consider the clients perspective on outcome.

Outcome research is often concerned with the question of whether counselling works in general. To this end the design of choice is often the randomised control trial, which depends on using large numbers of cases. This is not appropriate for the assessment of an individual practice and perhaps also not for evaluating a counselling service. Other approaches to evaluating outcomes, which look at individual cases, as propose by Elliott (2002) may provide a useful alternative approach. In this method various types of information are collected both quantitative and qualitative and then all the different evidence is weighed up using a reasoned argument approach in the same way as evidence in a legal trial. In particular an attempt is made to look for alternative explanations for any change that has been identified.

Outcome research has looked from a number of different perspectives at the question of whether counselling works. From this activity a number of different tools and approaches to measuring outcome have been developed. However the perspective of the practicing counsellor is missing and it is not clear how useful these tools are for practice. This study looks at Person Centred counsellor's approach to evaluating their own practice. The aim is to see what counsellors from a particular approach are doing in practice with regard to evaluation and what they see as important when looking at outcome.

Method

Six Person Centred counsellors were interviewed about their approach to evaluating their counselling practice. The interviews were recorded, transcribed and analysed using grounded theory methodology.

The Researcher

I am a Person Centred counsellor and at the start of the research project I had been practising for 3½ years, 1½ years of which was post diploma. Prior to that I had pursued a long career in IT.

My interest in the topic stemmed from my need to know whether counselling worked. Both whether it worked in general and also whether my particular practice worked. More specifically, 'how did I know it whether it worked?' Coming from a scientific background I had a desire for a yes/no answer to this question. The uncertainty of not knowing was uncomfortable. I also doubted the possibility of knowing the outcome of a single case because of the subjective and extremely complex nature of the activity.

Participants

The participants were all Person Centred counsellors with from 5 to 15 years experience and aged between 40 and 60. They all defined themselves as person centred therapists and had all trained to diploma level in the person centred approach. It was important to choose experienced counsellors so that they had some real material to reflect on and had had time to think about their work. It was also important so that they would be more confident about their capabilities and less defensive Skovholt and Ronnestad (1992). The participants were all known to the researcher and it was anticipated that this would help them be more open in the interview.

Although the study was restricted to counsellors using the Person Centred approach it was important to ensure that a variety of experience was represented both in terms of their experience in different settings, their training and also in other related roles, (defined as theoretical sampling in Strauss and Corbin (1998)).

Four participants were female and two were male. Their experience of different settings included work with students, in schools, private work, in community projects, EAP work, work in voluntary agencies, in primary care and marriage guidance. The respondents were trained on different person centred courses; PCT Britain, Jordonhill college, Wigan college and Persona. **Error! Reference source not found.** illustrates the respondents other roles.

| Roles | Number of Respondents |
|--|------------------------------|
| Counsellor Supervisor Trainer Manger of counselling service | 2 |
| Counsellor Supervisor Trainer | 2 |
| Counsellor Supervisor | 1 |
| Counsellor | 1 |

Table 2: Related Roles**Interviews**

Two weeks before the interview each participant was given a letter describing the subject of the interview, explaining confidentiality safeguards and seeking informed consent. In order to allow some time for reflection the letter included a list of the main research questions being asked:

1. What feelings does the word evaluation evoke for you?
2. Think of a case that you felt had a good outcome. What made you decide it was a good outcome?
3. Think of a case that you were not so happy about. What was it that made you unhappy?
4. How do you go about evaluating your own counselling work in general?
5. Ideally how do you think counselling practice should be evaluated?

Interviews lasted between 70 and 90 minutes and were recorded onto audio cassette tape. Within the structure of the questions above the interviews were open ended to allow the participants to explore the subject area in their own way. Where appropriate prompts were then used during the interview to ensure the subject was comprehensively covered and to help the participants explore it in depth. The tapes were then transcribed.

Analysis

The interviews were analysed using grounded theory methodology. The intention in this methodology is to identify common themes between the interviews and thus

create a description or model from the data itself rather than fitting the data into some external model. The theory generated is thus grounded in the data Strauss and Corbin (1998). In this methodology the researcher uses a phenomenological approach to analysing the data but within the particular context of the research question. The data is always being regarded from the point of view of how it answers the research question. However, within this context, the researcher attempts to keep an open mind as to the meaning conveyed in the interview and not to let his own prejudices and assumptions interfere. In this way the method combines both traditions of hermeneutic and phenomenological inquiry McLeod (2001).

The transcribed interviews were divided into segments and each segment was analysed to extract the basic concepts or codes that it contained, (open coding Strauss and Corbin (1998)). Each code relates to a part of the text, which could be a few words or a sentence or a number of sentences taken together. Before starting the analysis of the second interview codes identifying common themes were collected together into groups or categories. Each category was labelled with a brief phrase that captured the essence of the theme that it described. As the other interviews were completed they were similarly analysed and the codes produced were either allocated to existing categories or used to create new categories.

After the third interview it was clear that the respondent's other roles had some impact on their view of evaluation and so the sample was adjusted to ensure respondents were included who had different other roles, (theoretical sampling Strauss and Corbin (1998)). As this process progressed the data (that is the interviews themselves, codes and categories) was considered from different viewpoints in order

to try and see a general model. For instance one view was that the participants looked at the client, the relationship and themselves when evaluating. However this did not seem to reflect all that the participants had described that they were doing. After completing the six interviews a general model emerged which was defined in terms of three main categories; *Awareness of the idea of evaluation*, *Obtains information* and *Weighs up the evidence*.

The resulting model has been constructed by me from the data and includes my own particular subjective perspective. Inevitably I will have been influenced by my experience of being a Person Centred therapist and also my background in IT. Awareness of influences such as these serves to allow a more open attitude to the data when analysing. To further limit the effect of my own experiences I did not perform a comprehensive literature review until after completing the analysis. This had the effect of allowing me to approach both the interviews and the analysis with a more open mind.

This is one particular view of the data, which can be interpreted in different ways and from different perspectives. This does not invalidate the work, on the contrary, the strength of the methodology is that it allows the creation of new perspectives and understandings about a particular phenomenon.

A software tool was used to aid the analysis. This consisted of a Microsoft Access database with a web based front end. The tool allowed a segment of text to be stored and associated with the set of codes that were created from it. Each individual code could be labelled and the text relating specifically to that code could be stored with it.

It allowed categories to be created and associated with a set of related codes. It was therefore easy to switch between category and raw data. It also meant that no codes or categories were lost.

Results

A total of 968 codes were created of which 827 were used in the analysis. Those not used were ones that did not relate to the research question, for example *The interview caused the interviewee to think about evaluation* and *Believes that the client's level of emotional literacy affects their personal power*. Codes were allocated to more than one category when appropriate. The results are summarised in Table 3: Main Categories Table. In this table the number of respondents that contributed to a category, that is the number of interviews in which it appeared, and the number of codes allocated to each category are identified. The number of respondents indicates the generality of the category. For instance the categories *Discusses with others*, *Discusses with the client* and *Discusses with supervisor* could be combined to create a single, more general category of *Discusses* which would figure in all of the interviews. The number of codes gives an indication of how much the respondents talked about that particular category compared to the other categories and consequently the number of detailed properties that were identified. These numbers do not give any more validity to any one category over any other.

Three main categories emerged from the data. Firstly the category *Awareness of the idea of evaluation* describes the interviewees' response to the idea of evaluation and what it means to them. Secondly the category *Obtains information* describes the process where evidence is noted about what are seen as important aspects of the

counselling process. Finally the category *Weights up the evidence* describes how the information that has been noted is analysed and clarified.

The interviewees are aware of society's expectations in regard to evaluation and there is a feeling that it is necessary to prove that counselling is effective in order to promote counselling as a worthwhile activity. Some interviewees thought evaluation was a good thing whilst others didn't. Evaluation is seen as a scientific and quantitative activity involving data collection and analysis, which was regarded as a difficult thing to do because of the subjective nature of counselling. There was also concern that evaluation may conflict with their approach to counselling. There was an awareness of this conflict in respect of the requirements of working in different settings. However the interviewees did define their own approach to evaluating their counselling practice.

Interviewees collect or are aware of a wide variety of different types of information about the counselling process. They note information about aspects of the process that they regard as important. Firstly it is important that the client gets out of the counselling experience what is important for them. So the client's own evaluation is important. This could be expressed simply as the client getting what they want although it is not as simple as this because the client may get something other than what they wanted when they came into counselling and still be very satisfied. Secondly it is important that the client changes in some respect. Counsellors look for evidence of change in the client. In some cases this conflicts with the client getting what they want because the client may not want to change. Thirdly it is important to develop a good relationship with the client. Evidence for success was related to the

quality of the counselling relationship. Fourthly it is important that the counsellor practice their craft well, in this case the craft is that of being a Person Centred counsellor, and this also enables them to get something out of the process for themselves. So their use of self is important.

Counsellors collect information from a variety of sources when evaluating their practice. They take note of what the client says about what is going on in their life outside the counselling room, what is going on for the client inside the counselling room and also what is going on for the client inside themselves; how they feel about themselves and their self awareness for instance. Counsellors take note of their own experience of what goes on in the counselling room. What they notice about the client. How the client may have changed: in how they are or how they speak or how they behave towards the counsellor for instance. Counsellors also take careful note of and make use of their own feelings when evaluating their practice. Their own feelings are seen as important in whatever area of counselling they may be considering. For instance how they feel about the client, how they feel in relation to what goes on in the counselling room and how they feel about their own performance as a counsellor.

When evaluating, use is made of activities such as reviews with the client, supervision and discussion with colleagues. These activities are used to both gather more information and also to help make sense of some of the information they have received about what is happening. For instance supervision and discussion with colleagues may be used to help clarify confusing feelings they may have. Reviews with the client may help to clarify what the client's experience of the counselling has

been which then provides more information with regard to the client's evaluation of the counselling.

Often different items of information may be conflicting. For instance the counsellor may feel that they have not been working very well, or doing as well in their role of a counsellor as they know they can, yet the client is changing and is happy with what they have got out of counselling.

The interviewees take into account many different aspects of the counselling process, the client's own evaluation, changes in the client, the counselling relationship and their use of themselves as counsellors. However when obtaining information some aspects were more in evidence than others. For instance use of self was almost exclusively what one interviewee talked about in terms of evaluation whereas for another it was almost absent. Evaluation didn't come out with a yes/no answer by putting these four aspects into a formula. It was more that each interviewee took notice of each aspect in varying degrees to monitor the continuous progress of the counselling.

Each of the main categories is described in more detail below with individual subcategories identified by italics.

Awareness of the Idea of Evaluation

Interviewees saw evaluation as a requirement of society. They were *Aware of the need to prove effectiveness* in order for it to continue as an activity. "In part I think it's important because of how the rest of the world, the store the rest of the world places on

evidence ... when I'm talking about it being important it mostly seems to me that's to explain and show the evidence to the outside world."

Evaluation is seen as a quantitative, rigorous, scientific activity, which needs to be carefully organised to measure things objectively, *Sees evaluation as quantitative*. It is not necessarily appropriate or possible to do this when counselling an individual client as this is a process oriented activity where the means to the end is as important as the end itself. Respondents were often more comfortable with words such as reflect and monitor to describe what they did. It was seen as difficult to do because of the subjective nature of counselling, *Sees evaluation as difficult*. Explaining one's evaluation to non counselling people was also seen as difficult to do. "And I don't know how you actually, really, put that into words that people would understand. Do you know what I mean? In terms of well ... 'I knew we were working well' ... how can I show you that was true. Except to say to you. And because I know you trust me you probably believe that. But if you didn't know me and didn't trust me how could I actually say what I know is, that's what it feels like."

There was *Concern about conflict with counselling approach*. For instance evaluation can be seen in general terms as being a judgment either of the client or counsellor which conflicts with the counsellor's desire to be non-judgmental. There was also concern about the fact that society might misinterpret the results of evaluation. "I just feel it rests ill with client centredness ... I'm not, not comfortable with the legitimacy of taking a client through a protocol about how he felt when he came ... it just feels suddenly imposing structure after ..."

Also society's expectations were experienced by the requirements of different settings. Though generally this was accommodated without impacting the counselling process.

Evaluation is affected by the duration of counselling. As it takes time to develop a relationship short term counselling may be evaluated more on the client having a good experience or achieving their initial goals.

Interviewees talked in general terms about how they approached evaluation, *Defines evaluation for self.* That it is a continuous process that occurs throughout therapy. A couple of interviewees talked specifically about looking at their own process, the client's process and the relationship.

A basic motivation for counselling is to effect change in the client, *Defines client change as a criterion.* "Would I be a counsellor if I wasn't there to help people effect some change in themselves? Probably no." So that generally it was felt to be unsatisfactory when all that was happening was the provision of support for the client. Although it is also recognised that change can take time and that support may be required until it does. There is also an awareness that wanting client change is in conflict with the idea of not wanting to have an agenda for the client. It is therefore clear that the client must want to change and this relates to the categories *Client motivation* and *Shared commitment.*

Obtains Information

There are two main parts to the process of obtaining information. The first is identifying what information to collect. What are the important aspects of the counselling process that indicate success or failure? The second is how the information is collected. The practical activity of collecting the information and where it comes from.

Identifies what's important

Interviewees identified various characteristics that indicated that therapy was more or less successful. These aspects can be considered in four main groups: the client's evaluation, client change, the quality of the relationship and the counsellor's use of self.

Client satisfaction, the client getting what they want from counselling, is an important indicator of success. That counselling has helped the client by perhaps lessening their distress or it has allowed the client to deal with a particular problem that was important to them. "but also to me the more important side of it is the client's evaluation. You know, are they getting what they want, is it working for them, is it helping them?" An important aspect of being able to get what they want is the *Client's motivation*. Their motivation to do therapy, their desire for change and to work hard. So when assessing the success of a case the interviewees would also take the client's level of motivation into consideration.

Two main aspects of client change were identified which were *Changes in the client's external world* and *Changes in the client's inner world*. Examples of changes in their external world included doing things they couldn't before, making new or different relationships or being more assertive. Changes in a client's inner world were such things as how the client felt about or experienced themselves. For instance the client liked themselves better which was described in such terms as being "more accepting of themselves" or "kinder to their inner child". Or the client was able to "understand

themselves more". Or the client finds more satisfaction in their life without a change in circumstances. In general the client trusted themselves and their decisions more.

The *Quality of the counselling relationship* was regarded as of central importance. For successful counselling the relationship should develop over time and be strong enough to sustain the difficulties of the therapeutic process. Good quality relationships are described as open, connected, engaged, trusting and warm. The counsellor and client having a *Shared commitment* is a particular aspect of this. This includes having a common understanding about the aim of counselling and coming to mutual decisions and understandings about its process and progress. In general "sharing the journey".

The counsellor also looks at their own practice. Did they follow *Ethical practice*? Were they conscientious? Were they the right person for that client? Did factors in their outside life such as illness affect their counselling. How was their *Person Centred practice*? How well were they able to practice the Person Centred model of counselling with that client? "From my process one of the things I've said is how effective am I able to be and that's something about how much of me can I bring, am I able to bring, into the counselling process. And when I started to really think about that it was ... it's about how open, really how open I am ... it's about my struggle to offer the core conditions." Finally, part of whether a case has been successful is what the counsellor themselves has got out of it, *Personal satisfaction*. Have they learned something and are developing as counsellors or have they lived up to their own expectations of themselves? Satisfaction is also obtained from the sense of closure with the client, that the work is complete. So there is dissatisfaction when a client disappears, that is, stops attending

without any communication so no ending can be done. In this case not knowing what has happened is also part of the dissatisfaction.

Collects evidence

Information about the different characteristics of successful counselling is obtained both from the client and from the counsellor themselves within the counselling relationship, during the counselling process.

The counsellor *Obtains the client's evaluation* of the counselling. This can be done through reviews, through end of counselling questionnaires, discussion with the client at the end of therapy and through the counselling process itself. They also use *Client reports of changes* both in their life outside the counselling room and their experience of themselves. "How I would determine that changes had been made would be based on her accounts about what was going on in her life ... so it was measuring how she was talking about it differently, perceiving it differently and the effect it was having so that's where I was picking up because she is the window into her life, I don't know what goes on in her life really except what she tells me." The counsellor also *Uses the client's experience* of the counselling process. Their descriptions of what has been facilitative such as being given space to hear themselves or that the counsellor was just naturally being themselves or was a mirror or the client may refer to a particular event as significant for them. Also the client's descriptions of how the therapy worked, describing their own process.

The counsellor *Experiences the client in relationship*. The fact that the client can be angry with the counsellor or talk about shameful and difficult things is used as evidence that the relationship is open and safe. The fact that the counsellor sees the

client "reflecting deeply" or "accessing significant meaning" is used as evidence that the relationship is connected or engaged. The counsellor also *Observes the client behaving differently*. For instance talking about themselves in a different way, perhaps by using more compassionate language. Or how the client relates to themselves, for instance that they are doing more self reflecting. It is particularly significant when the client does something that was previously difficult for them to do.

A counsellor *Uses own feelings* as evidence about what is happening in the counselling process. For instance feelings such as boredom, discomfort, uncertainty, tension and stuckness indicate that perhaps something is not working well in the therapeutic process and something needs to be attended to. Other feelings such as feeling good about the work, a sense of comfort or ease, a sense of clarity or just knowing indicate the process is being successful. Other feelings are in reaction to client behaviour such as surprise or excitement or being moved. There can also be more subtle reactions like a sense of warmth or a sense of the client working hard. "I almost burst into tears when he told me that. But with him he wasn't so much like that so when he said things like that it was ... I found it very moving ... It just about blew me away, I found that profoundly moving."

Weighs up the Evidence

The counsellor may need to assess or clarify or process the information they get about what is happening in counselling. They do this in a number of ways.

The counsellor *Assesses the usefulness of the client's evaluation*. How much does the counsellor trust the client's view? "Oh, you know, was she flying to health or something

like that, but actually, when I reviewed it, looked over it, it felt fine, it was a very truthful decision for her, that she could, that she was absolutely exhausted 'cause of the journey she had been on, she needed some resting time." If the client is dealing with some difficult issues then they may be very distressed and believe it is not working. The counsellor may not necessarily agree with the client at this point. However if they have experienced the client being able to express negative things then they may have more trust in their evaluation. In general end of therapy questionnaires are not seen as adding very much useful information.

The counsellor is helped in their assessment by discussion with their supervisor, colleagues and with the client. This can help to clarify what is going on for the counsellor, in the relationship and for the client.

The counsellor also balances or compares different information, *Makes comparisons*. For instance the counsellor may feel they didn't offer the core conditions very well but they also see that the client has been able to change. "I think almost that isn't as important at some level as knowing that I kind of failed myself a little bit but in fairness to myself I think it's done her a whole load of good."

Clarification of how well the counsellor is working is prompted by the counsellor questioning themselves, *Uses self*. Questions may be in response to something happening or just part of the continuous process of monitoring. The counsellor relies on their understanding of themselves to help get an answer.

The counsellor can also turn to theory to help them work out what is going on, *Uses theory*. Theory acts as a framework against which to evaluate the counselling process.

“...it's good for me to have that model that ... I suppose it tells me ... the client's telling me that the counselling is working and the model, the theoretical framework ... affirms it. It's great, I then believe in what I'm doing, you know. I believe in this model as well as hearing it from the client ... it's important that it's useful, I'm helping them and they are also describing it in ways that fit the model.”

| Main Category | Subcategory | Number of I/views | Num of codes |
|--|--|----------------------------------|-----------------------------|
| <i>Awareness of the idea of evaluation</i> | | | |
| | Aware of the need to prove effectiveness | 5 | 26 |
| | Sees evaluation as quantitative | 6 | 28 |
| | Sees evaluation as difficult | 6 | 26 |
| | Concern about conflict with counselling approach | 6 | 42 |
| | Evaluation is affected by the duration of counselling | 5 | 20 |
| | Defines evaluation for self | 6 | 21 |
| | Defines client change as a criterion | 6 | 23 |
| <i>Obtains information</i> | | | |
| | <i>Identifies what's important</i> | | |
| | Client satisfaction | 6 | 45 |
| | Client's motivation | 6 | 24 |
| | Changes in the client's external world | 6 | 12 |
| | Changes in the client's inner world | 6 | 43 |
| | Quality of the counselling relationship | 6 | 30 |
| | Shared commitment | 5 | 19 |

| | | | |
|--|--|---|----|
| | Ethical practice | 6 | 47 |
| | Person centred practice | 6 | 60 |
| | Personal satisfaction | 6 | 35 |
| | <i>Collects evidence</i> | | |
| | Obtains the client's evaluation | 6 | 52 |
| | Uses client reports of changes | 5 | 19 |
| | Uses the client's experience | 6 | 30 |
| | Experiences the client in relationship | 6 | 41 |
| | Observes the client behaving differently | 6 | 30 |
| | Uses own feelings | 6 | 53 |
| | <i>Weighs up the evidence</i> | | |
| | Assesses the usefulness of the client's evaluation | 6 | 42 |
| | Discusses with supervisor | 6 | 36 |
| | Discusses with others | 3 | 13 |
| | Discusses with the client | 6 | 33 |
| | Makes comparisons | 5 | 23 |
| | Uses self | 6 | 49 |
| | Uses theory | 4 | 19 |

Table 3: Main Categories Table

Discussion

Evaluation for the interviewees seems to be governed by what they are trying to do as Person Centred counsellors and is an integral part of their counselling activity. As such they perform an extremely sophisticated activity. They take note of a large amount of sometimes conflicting and imprecise data and assess it against a number of different and sometimes conflicting criteria. In most cases the result of the evaluation at the end of a case is not a simple yes/no answer, not that this case was successful or this case was not successful. It is more that this aspect of counselling worked well, this aspect didn't work so well. The following quote gives a flavour of this complexity and illustrates a number of the subcategories of *Obtains information* and *Weighs up the evidence* described in the previous section:

“And then with, when I think about the relationship, I guess I said some of this, I put ... for me an excellent outcome, if we start from the excellent and work back the way, is when there is real depth of contact and by that I guess it's when I have the sense that the client is able to ... you know it's like how people can really kind of go down in their process and kind of access quite deep meaning, quite significant meaning in their process. And it's almost as if, in a funny kind of way, you are simply along side that, you're not provoking anything, it's like, I guess, when the client is able to really ... reflect, it's almost like they're by themselves with you that ... that's not a distancing thing like it's very intimate, that is completely, such an intimate moment. That for me is gold level, I love that, that feels so very special and I guess there's something in there about that I find that very deeply satisfying. So I guess it's like depth of contact depth of process but even if I come up the way there ... and it's not ... and what I think is curious is that it really is not about how much the client likes me or how much I like the client I think that can help, although latterly I've actually begun to think that liking the client can be a real hindrance at times because it's kind of the rose tinted spectacles bit. So I guess for me these days I value ... which is back to my indicators of success ... I value feeling able to be objective in my client work. What am I saying because I'm wandering about here? I

mean ... OK, so things like in the relationship, can the relationship sustain conflict can the relationship move through stuckness, can the relationship survive a break, can the relationship survive either me or the client being off the wall or not very present ... yes, can the client survive me being not good enough or can the I survive the client just being absent so it's like can the relationship survive difficulty. So those to me a real good indicators of success and I guess all that is around long term work."

Evaluation for Person Centred counsellors is embedded in the process of counselling itself. It does not appear to be a separate activity. Through taking part in this research project some of the interviewees came to a realisation that they did in fact evaluate their practice. "Yes for somebody that resents or rejects evaluation I do quite a lot of it really". They hadn't seen that what they were doing could be regarded as evaluation, they were just doing the activity of counselling. Counsellors are continuously evaluating what is going on in counselling from the start to the finish of each case and sometimes beyond.

When looking at the results of this analysis in relation to the approaches to outcome assessment described by the research papers in the introduction there are some interesting comparisons.

Evaluation in this study includes aspects of assessing outcome as defined by research and also aspects of self assessment or reflective practice (subcategories: *ethical practice, person centred practice* and *personal satisfaction*). It can be seen to be a much wider exercise than that defined by outcome research. One way of looking at this is to consider that in most professions there is some form of appraisal system to monitor an employees' performance. This often includes both meeting targets or key

objectives which could be compared to outcome assessment and also performance of personal skills which could be compared to self assessment in the way that it is defined in this study. One consideration here is that there is not a one to one correspondence between how well the counsellor does their job and outcome for the client. Interviewees identify cases where client change has happened which has resulted in a good outcome for the client even though they felt their level of person centred practice was not up to scratch. Conversely they may perform well as a counsellor but there is not a good outcome for the client. Hence other factors such as client motivation need to be considered.

When considering the outcome assessment part of evaluation the general process that respondents followed was similar to that used in outcome research in terms of identifying criteria, collecting data, using both client and therapist perspective and analysing data.

However there are major differences. The process is not very formalised. None of the interviewees used any formal evaluation tool such as described by Barkham, Evans and Mellor-Clark (1998) or Ogles and Lunnen (1996) even though some were involved in using such a tool in service evaluation exercises and some were comfortable with the idea of using such a tool. Perhaps it is not surprising that this is the case when one considers that some of the attitudes to the idea of evaluation are that it is difficult and may conflict with their approach. Most had experience with client end of therapy satisfaction questionnaires but the results of these did not seem to add much to their assessment. Their personal experience of the client was valued much more highly.

Respondents used a variety of sources of data about a wide variety of different aspects (content and social role in terms of Lambert, Ogles and Masters (1992)) for their evaluations. However, except for discussions with supervisor and colleagues, they didn't use any source that was independent of the participants.

The methods and tools developed for outcome research appear to be of little use to, or at least little used by, practicing counsellors. In some ways the scope of outcome assessment from research seems quite narrow when compared to the activity of evaluating practice described here. For instance a large part of evaluation for these therapists was in considering their own performance as practitioners. This also involves using theory as framework for their assessment. This aspect of evaluation is hardly touched on in the outcome research literature reviewed except as one part of the Elliott (2002) approach. The other main area that was assessed was the quality of the counselling relationship itself as well as such things as the client's motivation and shared commitment. These aspects are also not generally considered when using assessment tools.

There seem to be some similarities with the method of single case assessment described by Elliott (2002). Lots of information is obtained from different sources including the client's evaluation of benefit. Its validity is considered and conflicting evidence is compared. A process-outcome view is taken and significant events are used as evidence. However in this study there is no specific attempt to look for non-therapy events to account for any change and the process is not systematic.

When considering the criteria for change it is clear that the criteria of importance include ones similar to those obtained in studies of client's view of outcome Strupp and Connolly (1996). So changes in self concept are considered very important as well as interpersonal and presenting problem issues.

There are a few limitations to this study that should be considered. This was my first grounded theory analysis and that fact may perhaps limit its quality. Certainly the fact that only 6 respondents were used and there was only a limited attempt to determine contradictory evidence for the categories needs to be taken into account. Also as mentioned earlier the fact that I am a person centred counsellor talking to person centred counsellors may have limited my ability to be objective and stand outside the person centred frame.

This study has looked at a wide area of the experience of Person Centred therapists. Perhaps the different aspects of therapist's approach to evaluation such as identifying specific outcome criteria could be looked at in more detail. Further work could be done in comparing the experiences of therapists from other approaches such as cognitive behaviour, psychodynamic and those using eclectic or integrationist approaches.

The respondents in this study did not use the tools and methods developed by outcome research when evaluating their practice. This study could be used as a starting point to further develop ways of evaluating practice that are appropriate and meaningful to practitioners themselves and can also be used to validate their own practice. For instance the person centred approach to monitoring practice includes

consideration of the client's process, the counsellor's process and the relationship. This perspective is included in the sub category *Identifies what's important*. Perhaps the subcategories of *Collects evidence* could be used as a starting point to formalise this method.

In conclusion evaluation for the interviewees was seen to be a more general process than outcome assessment as carried out by outcome researchers. As well as outcome for the client it includes an assessment of the counselling relationship and reflection on the practice of the counsellor themselves. It is a continuous activity that is embedded in the counselling process itself rather than being formed from discrete measurements at particular times in the process.

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How Was It For Me: A Reflection on the Process of Doing an MSc

My Experience of the Process

My motivation for doing the MSc was mainly my interest in learning something new.

I have never done any “real” research before and didn’t know anything about qualitative methods and so this was an opportunity to do this. Also I had two questions about counselling that particularly bugged me. These questions came from my sceptical “scientific, logical positivist” self that always looks for rigorous cause and effect answers. The first question was whether counselling worked at all.

Although I could value counselling as an activity in itself, it seemed to me that the activity was much too complex to prove scientifically that it was effective. In my diploma course we had been told that research had proved that it was effective but I was sceptical because it seemed that the trainers would be biased. What was this research anyway and was it valid? The second question was whether my own practice worked. Was I any good as a counsellor? When a client finished counselling with me how did I know whether it had worked, whether there had been any benefit for the client. Clients might tell me that it had had benefits but I was sceptical of that because they might just be being nice to me. After all we had been meeting for some time and were just saying goodbye, they might not want to hurt my feelings. I might feel that the counselling had gone well but what evidence did I have for this, my feelings were not really rigorous proof. It seemed somewhat arrogant to assume that seeing someone for one hour per week over six months might have more impact than other events that might happen during that time such as getting a new job or new

relationship. The following is an extract from my research journal written at the beginning of the course:

“What burning question do I have as a practising counsellor? The question is how to know that the counselling has been successful. This comes from the very unknowingness about counselling and especially Person Centred counselling. Trust the process we are told. But I want to know in order to improve my practice. It is difficult for myself to feel competent when there is all this unknowingness around. But I do feel competent. So what indicators are there that I use? This contrasts to my background of physical sciences where everything is known or can be known quite precisely. So how do other PC counsellors deal with this unknowingness. Is it a problem for them at all? How does the uncertainty affect the counsellor”.

As I thought about these initial questions many more came to mind. What does effective mean, what does outcome mean, who's criteria are we judging it by. What is the connection between outcome research and evaluating practice.

I wanted to enjoy the process of doing the MSc so my intention was to not put myself under time pressure and to not give up any of my other activities in order to do it. The fact that it was part time and was extensible would allow me to do this. I have completed the work without giving up any of my main social and work activities. But in order to complete the work I have avoided doing things and have put things off. However it does not feel as if I have missed out on anything and this is perhaps the most important aspect. The process has also not been completed without feeling the pressure of time. In order to progress I have had to set myself targets and to

sometimes force myself to get down to work when I didn't really feel like it. For the most part when I have pushed myself the work has been enjoyable. However at other times when I felt stuck or felt that what I was doing wasn't good then pushing myself to work tended to be counter productive. I would tend to just sit there for hours with nothing happening and feeling bad. I have learned that the best thing to do in this case is to stop. After a day or two I will feel better about the work and then I will be more effective again. This works well when I'm not feeling under time pressure but time pressure makes this difficult as I then have to deal with the feeling that I need to get down to work.

For a lot of the time I have felt enthusiastic about the work and have really enjoyed doing it. I have found it interesting and learned a lot. However there have been times when I have doubted my ability to do the work. Have felt that it wasn't good enough and that I wasn't doing it right. At these times I got very down. These are familiar issues for me and were exacerbated by this being a new process for me and in doing it alone. When I felt like this I did seek some support but this was not easy to find and I have a tendency to struggle on, on my own. In future if I embark on a similar exercise I will certainly ensure that there are more people available to work with and who are available to talk to face to face. Email doesn't work so well for me in these cases. I think the main thing I need at this time is reassurance.

I didn't do a literature review at the beginning and I started the research project with less clarity than I was aware of at the time. This made the interviewing difficult for me. I wasn't clear in my focus when interviewing. What I really meant by evaluation of practice. What the word evaluation meant for me. Whether I was talking about

single case or group of cases or practice as a whole, whether we were considering current or completed cases. What I really meant by outcome assessment tools. This had the advantage of not imposing my definitions on the respondents thus obtaining more of their own meaning. Also when doing the analysis I had a more open mind. At this point I can see that this in fact was the case and was beneficial. But during the process itself it felt very insecure not to have a better idea of the whole subject area and this enhanced my feeling of not getting it right.

The other aspect was in applying the methodology. Getting to grips with a new methodology on my own was difficult. This was especially the case with a qualitative approach because I have spent my whole life, and am most comfortable, with quantitative approaches to investigation. Periodically through the process I was fearful that I was doing it wrongly. This then led me to feeling that what I was doing was no good and that I had wasted loads of time and would have to start all over. It felt quite overwhelming as the whole job of doing a grounded theory analysis seemed like a massive amount of work. Sometimes it felt like I would never finish it. I suppose that this was partly because never having done this kind of thing before I didn't have any idea of how long it would take. The other aspect of feeling that what I was doing was wrong was my struggle with the qualitative paradigm. The fact that it included the subjective and was a constructivist approach to analysis was difficult for me to grasp. I kept thinking that all I was producing was a reflection of my own thoughts and feelings about the subject area and not those of my respondents.

The sheer volume of data was quite daunting. There were two sides to this. The first, and the one that is written about most often, was the feeling that I would never find

any framework or structure that would fit. Mostly this is talked about in terms of meaning emerging from the data. For me, and perhaps this again reflects my IT type background, it felt more like finding an overall structure that explained the data. I would read and reread my original preliminary categories, their codes and the text until it didn't seem to mean anything anymore. The other side was the fear that I would lose data if I changed the analysis and it would take ages to reinstate it. For instance if I was considering a category and decided that the codes would be better distributed into other categories then I was fearful that having done that, which would take a lot of time, I might have to go back to the original category. I would then have lost so much time, it was a complete waste, and it would never be finished. This contributed to a feeling of not being able to move forward, to not being able to take a decision about which direction to go. In fact from time to time I had a feeling of panic and felt frozen, unable to stand back and take a broad view or make any decision about how to proceed at all. This was particularly acute in the period after I had completed analysing all the interviews and had obtained the codes and preliminary categories. I had had a supervision session where I had produced an alternative model. This was a description of what was going on that had been around in the back of my head and that I had perhaps verbalised for the first time. When I got back from the supervision I wrote down this model. However it felt very quite scary to go from where I was to this new model. It started to come together when I allowed myself, or accepted that it would OK, to go through all the categories one by one and see how they fitted into the new model. This then became the process where I actually created the details of the model and fleshed it out.

Some of the difficulty I had was due to using the computer software. This I think is particularly in terms of moving the data around in order to see possibilities for different categories and structures. Using codes and categories written on cards would definitely have been easier and quicker. I perhaps allowed myself to be bound too much by the capabilities of the software. However having started the analysis by using it I would have found it difficult to give it up. It also had the great advantage of ensuring that no data was lost and in capturing the model once it had been created.

Reflections on my Approach to Methodology

This has been a great experience in learning how to do Grounded theory. I tend to learn by experience rather than reading. So initially I read Strauss and Corbin (1998) and Rennie, Phillips and Quartaro (1988) and then started. During the analysis of the first interview I gave a coding example to my supervisor who gave me some feedback and I realised I wasn't relating the labelling of the codes to the research question. I therefore redid the coding of the first interview and this allowed me to start developing categories.

After completing the analysis I read more about grounded theory, particularly Punch (1998) and Rennie and Fergus (2001). I was able to relate these explanations to what I actually did and this has convinced me that I have completed a Grounded Theory analysis but probably not as effectively as I could have. I did too much open coding, I did this for each interview slavishly, and probably stayed too close to the data. It would have been better to spend more time developing categories and main categories earlier on so that I could use the subsequent interviews to compare these and develop their properties. I was developing alternative categories throughout the process but

these were often in order to create a structure to hold the codes because otherwise it seemed the amount of data (number of codes) would be unmanageable. I could have created categories more rigorously and also identified their properties more clearly so that this would have driven theoretical sampling and saturation more clearly. I didn't "Dip and skip" Punch (1998) enough. The result was that probably the process took longer than it needed to.

The paper by Rennie and Fergus (2001) has relevance to me in two respects. Firstly with a very positivist background I was very cautious when categorising staying very close to the literal meaning of the text thus generating hundreds of categories (codes in my scheme). This article helps to answer a question I had about the methodology, which was: "At what level/generalality to create categories and does it matter?" The suggestion in this paper is to abstract more at the initial coding stage. Also in my creation of the main model and main categories I seemed to rely on the Embodied Categorisation method. That is, the categories I created seemed to fit. In Rennie's words from that paper "I mean this is sort of a sense of fit".

I found that the process of creating categories influenced how I looked at the data. In considering a piece of data or code it was easier to relate it to an existing category than to see new categories in that data. Initially I found it difficult to ask the question "what is he doing here". That is, looking at the data in terms of actions. This is crucial to answering the research question and also creating a model. This was perhaps related to my confusion about the research question. Was I looking for the criteria that the interviewees used in order to determine whether their counselling was successful or was I looking more generally at how counsellors evaluated their practice? I was in

fact doing both but the question “how are they evaluating their practice” or “ what are they doing here” would have been a more useful attitude.

Some of this struggle however is due to the tension between the hermeneutic approach and the phenomenological approach that are both embedded in the Grounded theory methodology. A quote from my journal illustrates me asking the question:

“It seems like how you approach the data, i.e. which question you have in mind, influences what you see. E.g. I could just look at what are the success criteria for outcome.”

And then giving myself an answer after supervision:

“Yes this is the tension between hermeneutics (having a frame in mind which is the question) and phenomenology (within that frame being open to the raw experience). If only phenomenology then just have raw experience and the structure of my question doesn't come out.”

Critique of the Enalysist Software

I found the idea of using some software to help with the grounded theory analysis very attractive. Having worked in computing I was very comfortable with this idea. It also seemed that it was an ideal tool for managing large amounts of data. Of course the difficulty with this was that as I did not really understand what was involved with doing a grounded theory analysis I had no way of knowing whether the software would really be helpful. The software had only been used once by the author. I discovered later that his approach to doing grounded theory was somewhat different to mine. On reflection it may have taken more time by using the software as I have

described elsewhere. However the great thing about it is that I have the whole of the analysis captured on my hard disc so that I can continue with it in the future if I wish.

As the software was an important part of the analysis it seems important that I say something about its use and its deficiencies. The software was written with the idea of copying the tape into a digital file on the computer and then dividing it up into segments. Each segment would then be listened to in order to discover the meaning units. I couldn't do this because I found I needed to look at the text in order to think about it. Also playing and replaying a sound segment was very time consuming. I notice as I'm writing this that the use of time is a major consideration for me. I have always known that this is this case but perhaps I have not realised this before to such an extent.

I transcribed the text into a word file and then split it into fairly arbitrary chunks each chunk forming an Enalysist *segment*. Actually the chunks weren't that arbitrary but tended to contain a general point that the interviewee was talking about which is similar to a Meaning Unit used by Rennie, Phillips and Quartaro (1988). I cut and paste the text into the *segment note* field. For each *segment* I created a set of *codes*. These codes are described by Strauss and Corbin (1998) as concepts. For each *segment* I might create from 3 to 30 *codes* depending on the length of the segment and the density of the information in the text. For each *code* I cut and paste text into the *code note* field. When I was doing this I cut and paste a chunk of text, more than related exactly to the code, because I needed to keep some context in order to fully understand the *code* I had created without going back and sifting through the text in the *segment note* which was very time consuming.

This is a somewhat clunky operation. Although cutting and pasting is not a major effort it is time consuming going backwards and forwards between screens. Also sometimes there are *codes* that span the join between *segments*. A better way would be to be able to use the transcribed text directly by highlighting the text that refers to the *code*. When referring to the *code* the transcribed text would be brought up in a different window already scrolled to the relevant text. One could deal with the fact that the same *code* may refer to different parts of the text by creating a list and giving the user the option of scrolling through the list. That is, the user would be offered the option of looking at the next piece of text that refers to that *code*.

I have created more than 1000 *codes*. I know that some of them are the same and I should coalesce them to get a set of unique ones. When creating the *codes* I found it time consuming to go through all the existing *codes* to check if the new one already existed. It seemed easier to allocate the *codes* into different *categories* as I was going along and then coalesce the *codes* later. That way it is easier to see *codes* that are the same as there is a manageable list within each *category*. The problem with this is that coalescing 2 *codes* into one is very time consuming especially when I want to keep all the text notes. A specific function to do this by just specifying the two *codes* to be coalesced would be very useful.

My initial set of *categories* was not the one that I ended up with. When recategorising I needed to be able to move codes around into different *categories* to see how they fit. This again is time consuming using Enalysist and I can see why people might use sets of cards with the code labels written on to easily move them into different groupings

to see how they fit. To do this using a computer tool I think one would need the *categories* and subcategories shown in one window probably displayed in a hierarchical way and with the ability to simply create a new *category* label and move it to the place in the hierarchy where it is required. Then, in another window have one particular *category* and the associated *codes*. One could then move the displayed *codes* to particular *categories* in the *category* window using drag and drop. Double clicking on the *category* in the *category* window would bring up that *category* in another window with its list of *codes*.

Currently Enalysist has just *categories* which can be linked together but there is no concept of a subcategories in a hierarchy. Though perhaps *codes* are intended to be use as subcategories and not for the many initial *codes* as I have done. This is another limitation for the way I have used it.

What I Learned for my Practice

My main revelation was about what evaluating practice was all about. I had started with an assumption that to determine if a case was successful one had to do some form of before and after measurement such as CORE or BDI. In fact in the beginning I was sceptical about the value of what I was doing because, well we already know you can use the CORE tool, which does the job. However later on I also thought that would tell me nothing about my practice because even if the measurement indicated a change in the client I did not know whether that was due to the therapy or some other event

My first interviewee thought that she did not evaluate her practice but as she talked about the subject she realised that in fact what she was doing was evaluation. She talked about monitoring herself in terms similar to the idea of “being a reflective practitioner” and that this was the most important thing one could do, and perhaps the only thing one could really be sure about. My third interviewee talked about three aspects of evaluation, the client’s process, the counsellor’s process and the relationship, which I was already familiar with. Suddenly I realised that assessing the success of a case was more about evaluating the process than doing a CORE type outcome assessment. That it was important to look for what was going on in the therapy. It was then very satisfying to read Elliott (2002) after completing my grounded theory analysis. This paper first of all justified my objection to using CORE for single case evaluation but also describes a more process oriented approach which linked changes noticed at the end of therapy with events that happened during therapy. Elliott’s justification of his assessment method in terms of producing a reasoned argument which assesses the balance of evidence in the way that is done in medical and legal decisions seems like a good way of getting away from the RCT approach and to be much more valid to single cases. This seems a much more appropriate approach to evaluating practice.

After spending 18 months thinking about outcome assessment and outcome research I feel I have some clarity about what this area is all about and how it relates to my practice. Mainly outcome research is about showing that counselling works per se, that it works in different settings, that it works for different client groups and that it works for different counselling approaches. This is useful to me when I am justifying counselling as an activity to the non-counselling world. But doesn’t seem very useful

to help me improve my practice. Process outcome research, which is trying to find out what aspects of the therapeutic process are beneficial seems to be more useful in this case. The types of tools developed in outcome research such as CORE, it seems to me, can be used to assess the effectiveness of different counselling services. Especially to ensure continued funding. But when comparing services it is important to look also at the context. What are the client groups, what are the counsellor's characteristics. How the service operates and so on. In the outcome research and service evaluation situations we are considering large numbers of clients. However when evaluating my own practice I am more interested in considering individual cases. I am wanting to reduce some of the unknowingness of the process. Or help myself trust the process better. The fact that therapy has been proved to work and I now actually believe that, does not mean that my therapy works. I could use CORE with each of my clients and over time I would build up some kind of profile. It may help give me confidence that my practice is successful, assuming that the measurements indicate positive change for the majority of clients. But I would still be plagued with the question of whether it was anything to do with therapy. If it turned out that the majority of clients didn't improve as measured by CORE then I would be looking at other aspects of my clients that might explain this. I would not take this evidence at face value. In other words even if I used CORE I would need to collect other information and would use CORE as corroborative evidence only.

I have not changed the way I assess my practice, which is in fact similar to the model that emerged from my research. However when I have finished my MSc and have more time I intend to look at ways of doing this. This would seem to be a good way of continuing with the work that I have been doing in the MSc.

Conclusion

Doing this MSc has been a major event in my life over the last 18 months. I have been really excited and enthusiastic about learning new things. Learning about counselling outcome research and about grounded theory and other research methodologies.

Interviewing experienced counsellors in depth about their practice has been fascinating, as has analysing in the interviews in detail. I have really enjoyed being stimulated to think and being engaged in intellectual activity. At the same time it has been a challenge and struggle from time to time to deal with some of the more difficult parts of my self, in particular my need to get things right and my difficulty with uncertainty.

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