University of Strathclyde

Faculty of Humanities and Social Sciences

Significant client disclosures in therapy: Context, process and effects

Jane Balmforth

Volume 2: Appendix

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Copyright statement

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Appendices

Appendix A: Preliminary study of clients' post-session descriptions of disclosures

Clients' post-session descriptions of helpful disclosure events in therapy

The findings of this preliminary study, carried out in 2007/8 by the researcher and her first supervisor, Professor Robert Elliott, led to a further exploration of one of the disclosure descriptions (Description 89); this event was then analysed using CPA and developed into the pilot study, described in detail in Chapter 5 of the main volume of this thesis.

Disclosure to the therapist is considered as central to the process of clients' growth in therapy. In this qualitative, phenomenological investigation, two linking studies were carried out. (1) Helpful Aspects of Therapy (HAT) forms (post-session questionnaires) were examined and rated for possible descriptions of helpful disclosure. (2) A form of discourse analysis was then used to analyse the language that clients had used in the descriptions that were confirmed as disclosure events. Findings indicate that (a) clients found disclosure events significantly helpful and (b) clients provided a valuable insight into their experience of disclosure by using a rich and varied body of language.

This qualitative research into client descriptions of disclosure consists of two connecting studies. For the first study, the first researcher used the Oxford English Dictionary (1989) definition of disclosure to examine Helpful Aspects of Therapy forms (HAT: Llewellyn, 1988) for client descriptions of disclosure. This produced a body of possible client disclosure descriptions which were then assessed by independent raters as to disclosure content. The findings of the rating exercise

confirmed which descriptions were considered to be disclosure events. For the second study, the researchers carried out a form of discourse analysis on the language used by clients to describe disclosure in this data.

The aim of these studies was to increase our understanding of how clients experience disclosure as a helpful event in therapy and of the linguistic resources used by clients to construct accounts of important disclosures.

Study 1: Method

This study drew on an archive of approximately 2,000 Helpful Aspects of Therapy (HAT) forms completed by clients during four studies that began in the USA in the 1980s. Two of the studies focused on clients suffering from Depression and Post Traumatic Stress Disorder respectively, with a maximum of twenty sessions per client. The remaining two studies, (CSEP 1 and CSEP 2), were practice-based research, offering forty sessions to clients who presented with a wide range of clinical distress.

The therapists in all four research programmes came either from a process-experiential (PE) or a cognitive behavioural (CB) counselling background with a range of experience.

While this information about the archive is included for context, Taylor (2001) points out that 'analysts may use material which they had no role in collecting' (p.18.) Thus, the focus is purely on the text produced by the clients rather than the clients themselves.

The HAT form is a questionnaire developed by Llewellyn (1988) and completed by clients immediately after each session of therapy, asking them to describe and rate the most helpful and hindering aspects of the session. The forms provide a rich source of events which clients feel have been significant; they are invaluable as a means of discovering more about helpful and hindering experiences in therapy (Elliott and Shapiro, 1992).

The Oxford English Dictionary (OED) (1989) defines 'disclose' as 'to open up to the knowledge of others; to make openly known, reveal, declare'. 'Disclosure' is defined as 'the action of disclosing or opening up to view; revelation, discovery, exposure'. (See Appendix 1 for the etymology of 'disclosure'.) We used this definition as a starting point to examine the HAT forms for client descriptions of disclosure.

The first author studied the HAT forms, looking for what she perceived to be client descriptions of a disclosure event as the most helpful aspect of a therapy session, based on the OED definition (1989). In order to reach a consensus on a body of disclosure events she selected 50 descriptions which she felt contained the essence of disclosure according to the OED definition described above. She combined these

descriptions with 50 descriptions that did not meet her criteria of disclosure and rated each one, using a four-point confidence rating scale of 0-3 (Elliott et al, 1985):

0 = this description is clearly not disclosure

1 = disclosure might be referred to but it is not very clear

2 = disclosure is probably referred to

3 = disclosure is clearly and explicitly referred to

The list of 100 descriptions and the OED definitions of *disclose* and *disclosure* described above were then rated by two research colleagues using the confidence scale. (Rater 2 has a doctorate in psychology, is from a person-centred/integrative orientation and is a lecturer and researcher in counselling. Rater 3 is a person-centred counsellor carrying out doctoral level research.)

Study 1: Findings

All three raters gave a score of either 2 (disclosure is probably referred to) or 3 (disclosure is explicitly referred to) to 34 out of 50 of the disclosure descriptions (68%). Raters 2 and 3 rated six of the disclosure descriptions as not indicating disclosure sufficiently clearly (0 or 1 on the confidence scale) and they did not agree with each other on the remaining ten descriptions.

When rating the non-disclosure descriptions, there were no examples of both Raters 2 and 3 giving positive ratings for disclosure (2 or 3 on the scale). However, there

were ten non-disclosure descriptions that either Rater 2 or Rater 3 identified as disclosure.

The data from the three raters was subjected to an inter-rater reliability analysis (Cronbach's alpha) using SPSS: the inter-rater reliability was .89, showing a high probability that the results were not obtained by chance, but instead represented a high degree of consistency among raters. The correlation between individual raters was similarly good: between Rater 1 and Rater 2 it was .77; between Rater 1 and Rater 3 it was .76 and between Raters 2 and 3 it was .67.

Study 1: Discussion

The results of this study confirmed previous findings (Elliott et al, 1991) that clients may experience a disclosure event as the most helpful event in a therapy session. Although only 34 descriptions out of approximately 2,000, or 1.7%, were confirmed in this study by raters as being disclosure events, the significance lies in the occurrence, rather than the frequency.

The lack of complete uniformity in the views of the raters on which descriptions showed disclosure shows that this is a complex issue to define and that each person brought their own viewpoint and subjective experience to the data. In this sense we acknowledge that we are not presenting a neutral truth here, rather we are investigating meaning and significance (Taylor, 2001.)

It was a limitation of the study that it was carried out using archived data without access to the clients themselves. This meant it was not possible to confirm the client's disclosure intent.

However, despite this limitation, the HAT forms provided a body of client data on disclosure. The confidence rating scale was effective in the collection of data which could then be analysed. This methodology could potentially be used to explore other client experiences in therapy.

Study 2: Method

The thirty four descriptions that were agreed by the raters as descriptions of disclosure were from 28 clients, 11 male and 17 female. Six descriptions were from different sessions with six clients.

These descriptions were analysed using a form of discourse analysis to examine the language that clients used to express their experience. Clients completed the HAT forms immediately after the counselling sessions while the thoughts and feelings evoked in that session were still fresh. Madill (2006) describes how discourse analysis is concerned with the ways in which text can offer a version of reality in a particular context (p.28). Reading the clients' comments provides us with their version of reality of the counselling session, or 'how it was for them'.

The authors examined the primary metaphors (Lakoff and Johnson, 1999) behind the language used for different senses of disclosure. These primary metaphors combine a physical or sensorimotor experience with a subjective experience (Lakoff and Johnson, 1980; 1999). They include 'Showing is Being Known' (disclose as revealing, unveiling); 'Difficulties are Burdens' (disclose as shedding a weight or burden); 'Clean is Good, Dirt is Bad' (disclose as a cleansing process.) The aim of examining these metaphors was to gain an added perspective on the clients' implicit meanings. Exploring the meanings behind the words which the clients choose to use may yield a deeper understanding of how a phenomenon in therapy is experienced (Elliott, 2006).

Having investigated the language that is available to clients to describe an experience of disclosure, we now turn to the analysis of the client data. To carry out the data analysis the first author used open coding from grounded theory methodology (Strauss and Corbin, 1998); this made it possible to distinguish the salient factors of (1) the language the clients used and (2) how the clients felt about their disclosures.

The first author divided the clients' descriptions into meaning units (MU) that each contained a separate meaningful expression of their experience (Levitt, Butler and Hill, 2006). She then coded the units into concepts focusing on two principal categories: (1) the language (verbs and metaphors) used by the clients to describe the disclosure and (2) how the clients felt about the results of their disclosure.

As the coding was not exclusive, a unit could belong in more than one category: one client description could contain units in both categories 1 and 2, depending on the language used and the experience described.

Although identifying information such as gender, age and ethnicity is not provided on the HAT form, we have included the gender of the clients for context.

(The description identification numbers are taken from the original list of 100 that was used for the rating exercise in Study 1.)

Study 2: Findings

I: Putting into Words

I.i: Verbs

The first concept was how clients described putting into words either their feelings or the details of their story. We extracted all the verbs from the descriptions and then focused on the verbs used by the clients to describe the act of putting something into words. These were all verbs that appeared in Roget's Thesaurus under the category *Modes of Communication* (2002; pp. 521-545).

The most frequently used verb was *tell* (11 descriptions). The word *tell* dates from pre-1200 (Room, 1999). Like *talk* (7 descriptions) which dates from the 12^{th} -14^{th}

century (Room, 1999), *tell* is related to *tale* (from Old High German *zellen*) or *story* (Barnhart, 1988) and in ten descriptions the clients explicitly mentioned the importance of telling or talking to someone:

'I was able to tell someone how I felt about the pregnancy...' (Description 5, female client).

'I told her [*therapist]* things that I never told anyone else before...' (Description 32, female client).

The next most frequently used verb was *admit*, which was used in 8 descriptions. *Admit* is defined as *concede to be true* by the Shorter Oxford English Dictionary (1956) and the descriptions conveyed a sense of the clients coming face to face with a truth in their therapy. For example Description 27 (female client):

'It felt good to be able to admit that I was tired of living the way I am.'

and Description 65 (male client):

'Admitting I felt angry toward my father.'

Other clients' descriptions indicate the painful depths of awareness that clients may reach when disclosing to the therapist:

'I admitted to (*therapist*) that I'm not the person I need to be in order to admire myself.' (Description 50, female client).

'I got to talk to someone about how I feel' (Description 40, female client).

I.ii: Metaphors

Fourteen descriptions contained metaphors to describe the disclosure event. The most frequently used metaphor was 'Showing is Being Known' (Lakoff and Johnson, 1999) (8 descriptions), using the concept of revealing something that had previously been concealed, which led to the client being more able to be known, both to themselves and to the therapist.

'My therapist mentioned self-hatred and that sort of led me into revealing something about myself.' (Description 46, female client).

'Just to be able to say some things I've kept inside.' (Description 76, female client).

Five clients used metaphors of hiding/being open, for example:

'I was finally able to discuss openly the acts of infidelity in my marriage.' (Description 92, male client).

In Description 100, a male client compared physical and emotional openness:

'Being under my bed always meant I was hiding from something. It is good to get this out in the open.'

Three clients used a metaphor of gaining a sense of relief from inner pressure:

'Just being able to vent about things I've been all choked up about.' (Description 81, female client).

'I got to blow off a little steam and that felt great, especially the part where I talked about my brother.' (Description 95, female client).

In Description 13 a female client combined several metaphors to create a powerfully vivid picture of her disclosure:

'The emotional stockpile of pain came spewing out as I released information that held the pain together.'

The client's use of the word *spew*, or vomit, to describe the painful information being disclosed to the therapist introduces a physical aspect of discomfort or sickness into her description. This concept of physical pain or difficulty is used in different forms by other clients, for example:

'I feel that things that are hidden are painful and disrupt my life.'
(Description 15, female client)

One client used the metaphor 'Difficulties are Burdens' (Lakoff and Johnson, 1999), which also describes physical discomfort – this time of carrying a heavy load or having a weight press down on the body. Here the physical experience has been transferred to a mental or emotional experience:

'Said something that would have been difficult. A burden off my chest' (Description 36, male client).

One client used the metaphor of cleansing in the sense of *eliminating* or *clearing* (Roget's Thesaurus, 1998). The shame is the unhealthy emotion, which is cleared away by disclosing:

'By talking about this event I have been able to *get rid of* a lot of shame' (italics added)
(Description 15, female client).

Another concept mentioned by clients was that of danger: either the explicit danger shown in the use of the verb 'dare':

'saying something I dare not say anywhere else' (Description 45, male client).

or the implicit danger expressed by a client in Description 80, who used the metaphor of an imaginary political event to express the enormity of the disclosure:

'Letting (*the therapist*) know what happened when I was 16-17 years old. I feel like the Pres. just released all the info (top secret) re JFK's assassination.'

II: Clients' Experiences of Disclosure

The second main category is concerned with how the clients experienced disclosure. Clients chose to report these experiences as the most helpful event of one session of therapy. From these descriptions we were able to understand how the clients felt the disclosure events helped them get closer to the issues that had brought them to therapy. In 32 units from the descriptions clients described their experience of different stages of disclosing. We grouped these in temporal stages: holding in awareness before disclosing; the quality of 'firstness'; and what they felt they achieved by disclosing and how they felt about it. This final group had a subgroup of the clients' feelings about having disclosed which could be a result in itself or a feeling about a change caused by disclosing.

II.i Holding in awareness before disclosure

Eight clients described holding the undisclosed material in their awareness before disclosing it to the therapist: suppressing, hiding or simply unable to tell other people about the issues they brought to therapy:

'I brought up sex in relation to our marriage. It's something I had been possibly suppressing.' (Description 75, male client).

Description 100 (male client) uses a physical example as well as the metaphor:

'Being under my bed always meant that I was hiding from something.'

Other clients had previously felt unable to voice the issue:

'I feel that I hadn't told anyone what I was going through' (Description 37, female client).

'I never really trusted anyone enough to talk to them...' (Description 40, female client)

II.ii First-ness

The quality of 'first-ness', or novelty is not explicitly stated in the OED definition of disclosure, yet 12 clients included an explicit or implicit sense of first-ness in their descriptions.

Seven out of 12 descriptions in this group stated explicitly that this was the first time the client disclosed the information, by using phrases such as:

'It was the first time (I admitted that the job is bad for me)' (Description 28, male client), and

'I mentioned feeling afraid all the time – I don't think I've ever admitted that before.' (Description 11, male client).

For other clients the sense of novelty in their disclosures was more implicit:

'I was *finally* able to discuss openly the acts of infidelity in my marriage.' (Description 92, male client) (Italics added).

An added dimension to this theme is clients putting into words a feeling or a thought that has felt taboo, or speaking the unspeakable:

'I was able to tell someone how I felt about the pregnancy – I wanted to end it. I don't think I ever told anyone that.' (Description 5, female client).

'Thinking how I would torch the kid who shot me. I guess I never talked about that before.' (Description 16, male client).

II.iii Results of disclosing to the therapist for clients

It is possible to glean a sense of what the revealing of their inner self meant to the clients in the words and metaphors they used about having disclosed.

There were 5 examples of clients describing the result of disclosing personal information to the therapist in the sense of having gained a new awareness or an awareness of a change. For two clients the result of disclosing was a realisation:

Description 89, female client: '(First time I'd ever talked about it [*abuse*] with therapist and) I realized its connection to my life.'

Description 56, female client: 'Finding out and actually admitting I do have some things I need to work on.'

For two clients the result of disclosing was feeling psychologically freed:

'I have been able to get rid of a lot of shame and was able to reason about the event.' (Description 15, female client).

'I have talked so I am not so hidden' (Description 18, female client).

And in Description 20, a male client describes how disclosing will help his therapist understand him better:

'I believe my therapist has become more aware of why I have such low self-esteem...'

Seven clients expressed the result of disclosing as a feeling:

'I am happy (that I finally expressed...') (Description 22, female client).
'It felt good (to be able to admit...') (Description 27, female client).

For one client disclosing to the therapist caused a particular emotion:
'(Telling someone else) gave me a calm-settling feeling.' (Description 97, male client).

Study 2: Discussion

The clients' language, including their use of vivid metaphors, illustrates their positive feelings about the experience of disclosing information to their therapist. These results are similar to the findings of Farber et al (2004; 2006) where the majority of clients felt 'good' or 'relieved' to have disclosed, and did not regret making the disclosure. In the current study, clients' descriptions also reveal the importance attached to the status of the therapist of being socially sanctioned to listen to what the client feels cannot be said elsewhere (Farber and Hall, 2002).

Nearly a third of the descriptions (12 out of 32) included the concept of 'first-ness'. This may be similar to the concept of newness, which Elliott et al (1994) describe as being a major element in insight events. For those clients, making the personal disclosure may have led to an insight and an increase in self-awareness. Rogers (1951) refers to the client connecting with their internal frame of reference through therapy. Kelly, Klusas, von Weiss and Kenny (2001) found that revealing a secret can lead to new insights, which in turn leads to people feeling more positive about the original secret.

The sense of novelty has been judged elsewhere (Stiles, 1987; Farber et al, 2006) as an important element in the context of counselling disclosure; the act of engaging in therapy, with its freedom from everyday social conventions, may mean that for the first time clients have the opportunity to put into words their internal experiences and experience a sense of relief in doing so.

Gaining insight from a disclosure to the therapist may also involve a form of what Stiles (1999) refers to as a meaning bridge where the client's disclosure creates a link for him or her to access a new awareness. This also demonstrates what has been variously referred to as theory of 'movement toward awareness of denied experience' (Rogers, 1951, p. 147), or the emergence of warded-off feelings (Horowitz, Sampson, Sieglman, Wolfson and Weiss, 1975).

The act of disclosing to the therapist often is not an end in itself, but the start of the client's process towards change and self-acceptance. It is as if disclosing allows the client to clear away the shame that was blocking his/her powers of reason, which then becomes freed up. The importance of revealing a secret, shameful, event demonstrates another effect of disclosure – being able to re-connect with a rational perspective on an experience, or 'a change in the direction of a more soundly based reasoning' (Rogers, 1951, p 142).

Limitations and further research

This was a qualitative investigation, which used two linking studies to explore clients' experiences of disclosure in therapy as described on HAT forms. The selective nature of the sample means that the findings may not be generalizable to clients' experience of disclosure in general and in particular to nonexperiential therapies. The first author's initial screening of clients' descriptions of disclosure was potentially idiosyncratic and different researchers or raters might have selected different descriptions and rated them differently (Taylor, 2001, p.17.)

Other limitations of the study were (a) it was not possible to study the link between helpful disclosure and outcome; and (b) client details such as age or background, were not available; these could have provided more context to the descriptions. The thin protocols meant that there was only one example each for two of the metaphors, whereas in Farber et al's studies (2004; 2006), these were reported as common metaphors.

Further research into how clients experience disclosure is needed to reveal more about facilitating and inhibiting factors, the extent to which clients prepare to disclose and how much they leave unsaid. More detailed research investigating the link between disclosure and outcome would also help clarify this complex area.

Despite the limitations of this study, examining the helpful aspects of disclosure for clients revealed powerful descriptions. By analysing the words and metaphors used by the clients we gain an added sense of the feeling behind the words. The language used provides a valuable insight into the inner experiencing of the client: we read in the clients' own words the significance of their disclosure in therapy.

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Appendix B: Helpful Aspects of Therapy (HAT) Form

HELPFUL ASPECTS OF THERAPY FORM (H.A.T.)
(Version 3.2; 05/2008)

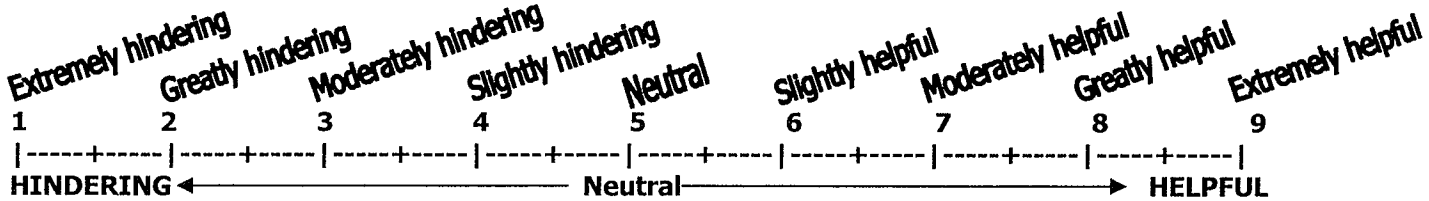
Therapist _____ Client ID _____

Date _____ Session _____

1. Of the events which occurred in this session, which one do you feel was the most **important** or **helpful** for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist or counsellor said or did.)

2. Please describe what made this event **important/helpful** and what you got out of it.

3. How **helpful or hindering** was this particular **event**? Rate it on the following scale. (Put an "X" at the appropriate point; half-point ratings are OK; e.g., 7.5.)



4. About where in the session did this event occur?

5. About how long did the event last?

Please turn over

6. Did anything else particularly **helpful** happen during this session? **YES NO**

(a. If yes, please rate how **helpful** this event was:

Slightly ☐$_6$ Moderately ☐$_7$ Greatly ☐$_8$ Extremely ☐$_9$

(b. Please describe the event briefly:

7. Did anything happen during the session which might have been **hindering**? **YES NO**

(a. If yes, please rate how **hindering** the event was:

Slightly ☐$_4$ Moderately ☐$_3$ Greatly ☐$_2$ Extremely ☐$_1$

(b. Please describe this event briefly:

Appendix C: Disclosure Question Form

After responding to this question please hand this sheet directly to your therapist. This information will be passed to Jane Balmforth.

Many thanks for participating in this research study.

8. In this session, did you reveal something important about yourself to your therapist? **YES NO**

(a. If yes, please rate how **important** it was to you:

Slightly ☐$_1$ Moderately ☐$_2$ Greatly ☐$_3$ Extremely ☐$_4$

(b. If you feel OK to do so, could you please indicate generally what you revealed?

Appendix D: Client post-session questionnaire: Session Effectiveness Scale (SES)

CLIENT POST-SESSION QUESTIONNAIRE
(Version 2.0; 05/2008)

Therapist _____ Client ID _____

Date _____ Session _____

Instructions. Please complete this questionnaire as soon after your session as possible. We use it to find out how you saw the session. We really are interested in your feelings about the session, so try not to worry about hurting your therapist's feelings. The information you provide will be used to improve the therapy we do, so both positive and negative feedback are welcomed. Unless we tell you otherwise, your therapist will not see your ratings. If you have a concern about either your therapy or the research, please speak to your therapist, the researcher assigned to your case, or to the Director of the Research Clinic (Dr. Robert Elliott, x 3727, room D303C).

1. Please rate how **helpful or hindering** to you this session was overall.	☐1 Extremely hindering ☐2 Greatly hindering ☐3 Moderately hindering ☐4 Slightly hindering ☐5 Neither helpful nor hindering; neutral ☐6 Slightly helpful ☐7 Moderately helpful ☐8 Greatly helpful ☐9 Extremely helpful
2. How do you feel about the session you have just completed?	☐1 Perfect ☐2 Excellent ☐3 Very good ☐4 Pretty good ☐5 Fair ☐6 Pretty poor ☐7 Very poor
3. How much **progress** do you feel you made in dealing with your problems in this session?	☐1 A great deal of progress ☐2 Considerable progress ☐3 Moderate progress ☐4 Some progress ☐5 A little progress ☐6 Didn't get anywhere in this session ☐7 In some ways my problems have gotten worse this session
4. In this session something shifted for me. I saw something differently or experienced something freshly:	☐1 Not at all ☐2 Very slightly ☐3 Slightly ☐4 Somewhat ☐5 Moderately ☐6 Considerably ☐7 Very much

Appendix E: Personal Questionnaire Form (PQ)

PERSONAL QUESTIONNAIRE (Problem Rating Form)

Client ID: _____

Date: _____

Session: _____

Interviewer initials: _____

Instructions: Please complete before each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today.

	Not At All	Very Little	Little	Moder-ately	Consider-ably	Very Consider-ably	Maxi-mum Possible
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7
11.	1	2	3	4	5	6	7
12.	1	2	3	4	5	6	7
Additional Problems (optional): * Add to my printed form	1	2	3	4	5	6	7

Appendix F: Clinical Outcomes in Routine Evaluation Outcome Measure (CORE OM)

CLINICAL OUTCOMES in ROUTINE EVALUATION

OUTCOME MEASURE

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

Date form given D D / M M / Y Y Y Y

Age

Male

Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	0	1	2	3	4	F
2 I have felt tense, anxious or nervous	0	1	2	3	4	P
3 I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4 I have felt O.K. about myself	4	3	2	1	0	W
5 I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6 I have been physically violent to others	0	1	2	3	4	R
7 I have felt able to cope when things go wrong	4	3	2	1	0	F
8 I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9 I have thought of hurting myself	0	1	2	3	4	R
10 Talking to people has felt too much for me	0	1	2	3	4	F
11 Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12 I have been happy with the things I have done.	4	3	2	1	0	F
13 I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14 I have felt like crying	0	1	2	3	4	W

Please turn over

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15 I have felt panic or terror	0	1	2	3	4	P
16 I made plans to end my life	0	1	2	3	4	R
17 I have felt overwhelmed by my problems	0	1	2	3	4	W
18 I have had difficulty getting to sleep or staying asleep	0	1	2	3	4	P
19 I have felt warmth or affection for someone	4	3	2	1	0	F
20 My problems have been impossible to put to one side	0	1	2	3	4	P
21 I have been able to do most things I needed to	4	3	2	1	0	F
22 I have threatened or intimidated another person	0	1	2	3	4	R
23 I have felt despairing or hopeless	0	1	2	3	4	P
24 I have thought it would be better if I were dead	0	1	2	3	4	R
25 I have felt criticised by other people	0	1	2	3	4	F
26 I have thought I have no friends	0	1	2	3	4	F
27 I have felt unhappy	0	1	2	3	4	P
28 Unwanted images or memories have been distressing me	0	1	2	3	4	P
29 I have been irritable when with other people	0	1	2	3	4	F
30 I have thought I am to blame for my problems and difficulties	0	1	2	3	4	P
31 I have felt optimistic about my future	4	3	2	1	0	W
32 I have achieved the things I wanted to	4	3	2	1	0	F
33 I have felt humiliated or shamed by other people	0	1	2	3	4	F
34 I have hurt myself physically or taken dangerous risks with my health	0	1	2	3	4	R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores

Mean Scores
(Total score for each dimension divided by number of items completed in that dimension)

(W)	(P)	(F)	(R)	All items	All minus R

Appendix G: Strathclyde Inventory (SI)

STRATHCLYDE INVENTORY v.4

Client ID _____ Male ☐ Female ☐ Age _____ Date ___/___/___ Session_____

Please read each statement below and think how often you sense it has been true for you DURING THE **LAST MONTH**. Then mark the box that is closest to this. There are no right or wrong answers – it is only important what is true for you individually.

	OVER THE LAST MONTH	Never	Only Occasio-nally	Some-times	Often	All or Most of the time
1.	I have been able to be spontaneous	☐0	☐1	☐2	☐3	☐4
2.	I have condemned myself for my attitudes or behaviour	☐4	☐3	☐2	☐1	☐0
3.	I have tried to be what others think I should be	☐4	☐3	☐2	☐1	☐0
4.	I have trusted my own reactions to situations	☐0	☐1	☐2	☐3	☐4
5.	I have experienced very satisfying personal relationships	☐0	☐1	☐2	☐3	☐4
6.	I have felt afraid of my emotional reactions	☐4	☐3	☐2	☐1	☐0
7.	I have looked to others for approval or disapproval	☐4	☐3	☐2	☐1	☐0
8.	I have been aware of my own impulses, desires or reactions	☐0	☐1	☐2	☐3	☐4
9.	I have expressed myself in my own unique way	☐0	☐1	☐2	☐3	☐4
10.	I have found myself "on guard" when relating with others	☐4	☐3	☐2	☐1	☐0
11.	I have made choices based on my own internal sense of what is right	☐0	☐1	☐2	☐3	☐4
12.	I have listened sensitively to myself	☐0	☐1	☐2	☐3	☐4
13.	I have felt myself doing things that were out of my control	☐4	☐3	☐2	☐1	☐0
14.	I have lived fully in each new moment	☐0	☐1	☐2	☐3	☐4
15.	I have been afraid of some of my feelings	☐4	☐3	☐2	☐1	☐0
16.	I have felt that I have to do things because they are expected of me	☐4	☐3	☐2	☐1	☐0

PLEASE TURN OVER

		Never	Only Occasio-nally	Some-times	Often	All or Most of the time
17.	I have been confident	☐0	☐1	☐2	☐3	☐4
18.	I have been aware of my feelings	☐0	☐1	☐2	☐3	☐4
19.	I have felt that I am a person of worth	☐0	☐1	☐2	☐3	☐4
20.	I have hidden some elements of myself behind a "mask"	☐4	☐3	☐2	☐1	☐0
21.	I have taken responsibility for my choices	☐0	☐1	☐2	☐3	☐4
22.	I have felt true to myself	☐0	☐1	☐2	☐3	☐4
23.	I have been able to hear my own feelings	☐0	☐1	☐2	☐3	☐4
24.	I have been able to resolve conflicts within myself	☐0	☐1	☐2	☐3	☐4
25.	I have felt threatened by others' words or behavior	☐4	☐3	☐2	☐1	☐0
26.	I have felt myself doing things that are out of character for me	☐4	☐3	☐2	☐1	☐0
27.	I have accepted my feelings	☐0	☐1	☐2	☐3	☐4
28.	I have conformed to what others think or want	☐4	☐3	☐2	☐1	☐0
29.	I have lived in a way which truly expresses who I am	☐0	☐1	☐2	☐3	☐4
30.	I have been able to understand those with whom I had personal contact	☐0	☐1	☐2	☐3	☐4
31.	I have felt it is all right to be the kind of person I am	☐0	☐1	☐2	☐3	☐4

Thank you for your time in completing this questionnaire

Appendix H: Change Interview protocol (CI)

Client Change Interview Schedule (v6; 10/2011)

After each phase of counselling, clients are asked to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the therapy. The main purpose of this interview is to allow you to tell us about the therapy and the research in your own words. This information will help us to understand better how the therapy works; it will also help us to improve the therapy. Your therapist will not be shown this information until you have finished counselling with them, and only then if you give us permission to do so. This interview is recorded for later transcription. Please provide as much detail as possible.

1. General Questions: [about 5 min]
1a. How are you doing now in general?
1b. What has therapy been like for you so far? How has it felt to be in therapy?
1c. What medications are you currently on? *(interviewer: record on form, including dose, how long, last adjustment, herbal remedies)*

2. Changes: [about 10 min]
2a. What changes, if any, have you noticed in yourself since therapy started? *(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*
2b. Has anything changed for the worse for you since therapy started?
2c. Is there anything that you wanted to change that hasn't since therapy started?

3. Change Ratings: [about 10 min] *(Go through each change and rate it on the following three scales:)*
3a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)
(1) Very much expected it
(2) Somewhat expected it
(3) Neither expected nor surprised by the change
(4) Somewhat surprised by it
(5) Very much surprised by it

3b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)
(1) Very unlikely without therapy (clearly would not have happened)
(2) Somewhat unlikely without therapy (probably would not have happened)
(3) Neither likely nor unlikely (no way of telling)
(4) Somewhat likely without therapy (probably would have happened)
(5) Very likely without therapy (clearly would have happened anyway)

3c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)
(1) Not at all important
(2) Slightly important
(3) Moderately important
(4) Very important
(5) Extremely important

4. Attributions: [about 5 min] **In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about?** (Including things both outside of therapy and in therapy)

5. Resources: [about 5 min]
5a. What personal strengths do you think have helped you make use of therapy to deal with your problems? (what you're good at, personal qualities)
5b. What things in your current life situation have helped you make use of therapy to deal with your problems? (family, job, relationships, living arrangements)

6. Limitations: [about 5 min]
6a. What things about you do you think have made it harder for you to use therapy to deal with your problems? (things about you as a person)
6b. What things in your life situation have made it harder for you to use therapy to deal with your problems? (family, job, relationships, living arrangements)

7. Helpful Aspects: [about 10 min] **Can you sum up what has been helpful about your therapy so far? Please give examples.** (For example, general aspects, specific events)

8. Problematic Aspects: [about 5 min]
8a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)
8b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?
8c. Has anything been missing from your therapy? (What would make/have made your therapy more effective or helpful?)

9. Ending therapy
9a. What was your experience of the ending of your therapy?
9b. What things, if any, helped you to end?
9c. What things, if any, made it more difficult for you to end? Was there anything missing/problematic about how your therapy ended?
9d. How do you feel/see/think about your therapist, now that therapy is over?

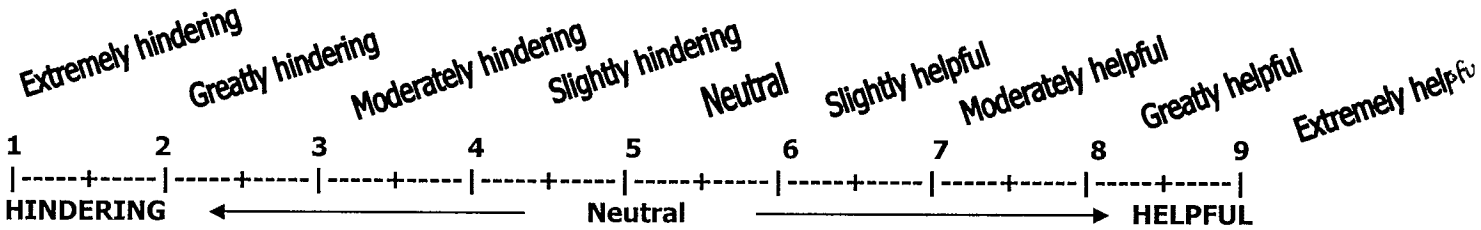
10. The Research:. [about 10 min]
10a. What has it been like to be involved in this research? (Initial screening, research interviews, completing questionnaires etc)
10b. Can you sum up what has been helpful about the research so far? Please give examples.
10c. What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of therapy? Please give examples.

11. Suggestions: [about 5 min] **Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?**

Appendix I: Interview protocol (adapted from Brief Structured Recall; BSR)

Interview Schedule

- **Find the disclosure on the recording with the client's help**
- Please indicate the points when the disclosure started and finished.
- Did you think about revealing this to the therapist earlier in the session or in previous sessions? Could you say whereabouts in the session you thought about this?
- If so, why did you not do so? What influenced your decision?
- What made you decide to disclose this to the therapist at this point?
- What helped you to be able to disclose at that point?
- How did you feel just before you disclosed this to the counsellor?
- How did you feel as you were making the disclosure? What were your thoughts? What were you trying to do by disclosing this to the counsellor?
- Just after the disclosure, and for the rest of the session, how did you feel about having disclosed the important information?
- When you reflected on the session afterwards, how did you feel about having disclosed to the therapist?
- How helpful to you do you think your disclosure was on a 9 point scale?



- What were the most helpful things that you did or said?
- What do you think may be different for you now that you have disclosed this to the therapist?

Appendix J: Application form for University/Departmental Ethics Committee and letter of approval

UNIVERSITY OF STRATHCLYDE

APPLICATION FORM FOR UNIVERSITY ETHICS COMMITTEE AND DEPARTMENTAL ETHICS COMMITTEES

This form applies to all investigations within the remit of the University's Code of Practice on Investigations on Human Beings. This includes all investigations with human participants undertaken by staff or students of the University of Strathclyde which falls within the remit of the University Ethics Committee (see Code of Practice, para 5.1) or the Departmental Ethics Committees (see Code of Practice, para 5.2).

However, this form should NOT be used for any investigation involving clinical trials (see Code of Practice, para 6.4) or medicinal products, nor for investigations involving staff, patients, facilities, data, tissue, blood or organ samples from the National Health Service. Applications for ethical approval for investigations involving the National Health Service in any way must be made under the governance arrangements for National Health Service Research Ethics Committees (see Code of Practice, para 3.2(d)) and where ethical approval is required from the NHS using the form issued by COREC (see Code of Practice, para 6.1).

Information sheets for volunteers and consent forms to be used in this study should be submitted with the application form for consideration by the Committee.
The application will be judged entirely on the information provided in this form and any accompanying documentation - full grant proposals to funding bodies should not be attached. Please explain any abbreviations, acronyms etc that you use. The Code of Practice (http://www.mis.strath.ac.uk/Secretariat/Ethics.htm) contains guidance on completing this application, on information sheets and on consent forms.

Applications which are not signed and/or do not include the required additional forms (e.g. participant information sheet and consent form) will not be considered by the University Ethics Committee and will be referred back to the Chief Investigator.

The form is designed for completion in Word, and should in any case be typed rather than handwritten. The grey-shaded text boxes on the form will expand to allow you to enter as much information as you require. If you have difficulty filling out the form in Word, please contact Gwen McArthur in the Secretariat (ext. 2472).

Checklist of enclosed documents

Document	Enclosed?	N/A
Participant information sheet(s)	☒	☐
Consent form(s)	☒	☐
Sample questionnaire(s)	☐	☒
Sample interview format(s)	☒	☐
Sample advertisement(s)	☐	☒
Any other documents (please specify below) Letter of invitation to participate	☒ ☐ ☐ ☐	☐ ☐ ☐ ☐

1. Chief Investigator (for the purposes of this application, this should always be the person responsible for the study at Strathclyde)

Name: Robert Elliott
Status (e.g. professor, senior lecturer): Professor
Department: Counselling
Contact details: Telephone: 0141 950 3727
E-mail: robert.elliott@strath.ac.uk

2. Other Strathclyde Investigator(s)

Name(s): Jane Balmforth
Status (e.g. lecturer, post-/undergraduate): Postgraduate student.
Department(s): Counselling
If student(s), name of supervisor: Professor Robert Elliott (first supervisor) and Professor Mick Cooper (second supervisor)
Contact details: Telephone: 0141 270 8282 (office) 0781 654 5367 (mobile)
E-mail: jane.m.balmforth@strath.ac.uk

Please provide details for all investigators involved in the study (*the text box below will expand to allow details to be entered*):

3. Non-Strathclyde collaborating investigator(s)

Name(s): n/a
Status:
Department/Institution:
If student(s), name of supervisor:
Contact details: Telephone:
E-mail:

Please provide details for all investigators involved in the study (*the text box below will expand to allow details to be entered*):

4. Title of the investigation:

How clients experience significant disclosures in therapy

5. Where will the investigation be conducted? (Note that the Committee reserves the right to visit testing sites and facilities)

At the University of Strathclyde Counselling Research Clinic or other location convenient to the participants

6. Duration of the investigation (years/months):

(Expected) start date: September 2008
(Expected) completion date: June 2012

7. Sponsor:

n/a

8. Funding body (if applicable):

n/a

Status of proposal – if seeking funding (Please cross as appropriate):

i) in preparation ☐
ii) submitted ☐
iii) proposal accepted by funding body ☐

Date of submission of proposal

Date of commencement of funding

9. Objectives of investigation:

Brief outline of the background, purpose and possible benefits of the investigation.

The objectives of the investigation are:

1. To explore the process that a client goes through before, during and after making a significant disclosure to the therapist

2. To explore the relationship between a client's disclosures and the outcome of the therapy

Disclosure is an essential element of therapy (Farber, Berano & Capobianco, 2004); however, the process that a client goes through of deciding what, when and how much to reveal to their therapist is not well understood. By interviewing clients about their experiences of making significant personal disclosures in therapy I hope to clarify helpful/hindering factors about this process. I will also invite clients to explore the link between their disclosures and the outcome of the therapy.

This investigation aims to benefit the practice of counselling by highlighting any factors that clients find helpful or hindering to them when they are considering self-disclosure to the therapist. The study also aims to shed light on the role of disclosure in the outcome of the counselling treatment and make suggestions about therapists' facilitation of disclosure.

Reference: Farber, B., Berano, K., & Capobianco, J. (2004) Clients' Perceptions of the Process and Consequences of Self-Disclosure in Therapy. Journal of Counseling Psychology, 51, 340-346.

10. Nature of the participants:

Number: 6-8
Age (range): 18 - 65
Gender of volunteers: male and female

Recruitment method(s)

I will send a letter (attached) to clients asking if they would be willing to be contacted and interviewed about disclosures they have identified on their post-session Helpful Aspects of Therapy (HAT) forms

Inclusion/exclusion criteria (if appropriate)
Participants will have revealed something to their therapist that they define as important on their (HAT) form

Screening procedure (if appropriate)
n/a

Any special skills, attributes, medical conditions
n/a

Any vulnerable participants (see Code of Practice, section 5.1(ii) and annex 2)
n/a

Justifications for sample size (e.g. power calculations)
The sample size is in keeping with an in-depth qualitative study of this nature.

Will data be anonymised and destroyed after use? If not, please give reasons.
All data will be kept confidential. Recordings will be stored securely as part of the Practice-Based Research data set, on a password protected data server in the research clinic in an encrypted file.

11. What consents will be sought and how?

(Consent forms and participator information sheets (and questionnaires where used) must be appended to this application

The participants will be asked to consent to being contacted and invited for an interview about any significant disclosure they mention on their post-session HAT form.

I attach the Information Sheet and Consent Form.

12. Methodology

Design: what kind of design is to be used in the investigation (e.g. interview, experimental, observation, randomised control trial, etc.)?

This qualitative research is intended to be an add-on study to the research currently being conducted in the University of Strathclyde Counselling Research Clinic using the Practice-Based Research protocol. Clients recruited through NHS organisations are excluded from this study.

The design will consist of tracking the disclosures in therapy of clients who have previously given their informed consent to participate in the study, using interviews and Interpersonal Process Recall (IPR).

Techniques: what methods will be employed and what exactly is required of participants?

Significant disclosures identified by the clients will be analysed using Comprehensive Process Analysis (CPA), a method developed by Professor Robert Elliott to analyse signifant events in therapy. CPA involves identifiying the key speaking turns of the client and therapist in the disclosure, identifying the factors that contributed to the event occurring as it did and when it did in the therapy and analysing the effects of the event as experienced by the client.

The procedure is as follows:

1. Participants identify a significant disclosure on the Helpful Aspects of Therapy (HAT) form, which is completed immediately post-session.

2. Participants are contacted by the researcher as soon as possible after the session and invited to arrange a time/place suitable for the interview.

3. Participants listen to the tape of the session and identify the beginning and end and key elements of the disclosure event. This will involve using Interpersonal Process Recall (IPR), a mixed qualitative-quantitative cued recall data collection method.

4. Participants are interviewed about their experience of making the significant disclosure to their therapist e.g. at what point they decided to make the disclosure, what factors affected the decision to disclose at that point in therapy, whether they had considered making the disclosure earlier in the session/therapy etc.

5. Participants will be asked in a short follow-up interview/questionnaire later in the therapy about any continuing impact of the significant disclosure on the therapy and any impact on the overall success/failure of the therapy.

6. The interviews will be recorded and transcribed.

Reference should be made to any of the following to be used in the investigation (see Code of Practice, section 5.1):

Invasive techniques ☐
DNA testing ☐
Administration of drugs, foods, liquids, additives, other substances ☐

Any deception ☐
Physical exertion/exercise ☐
Manipulation of cognitive or affective human responses, possibly causing stress/anxiety ☐
Highly personal, intimate and/or confidential information being sought ☒
Acquisition of bodily fluids or tissue ☐
Access to confidential data (e.g. medical reports) ☐

Description of the use of any of the above:
The client will be interviewed about their description of a disclosure as significant which may involve highly personal information. This information will be used anonymously to analyse the process that the client went through before, during and after the disclosure and the impact on the therapy outcome.

The duration of the study for participants and frequency of testing (if repeat testing is necessary)
The participant will be invited for one interview lasting no more than two hours about a significant disclosure they have made to the therapist. The interview will include IPR, where the client identifies the significant disclosure on the tape.

The client will be contacted again by phone or e-mail at a later stage in the therapy. The purpose of this contact is to ascertain whether the significant disclosure had any impact on the later stages or outcome of the therapy.

13. Potential risks or hazards:

Full details should be given of any potential risks or discomfort for participants, any burdens imposed and any preparatory requirements (e.g. special diet, exercise), as well as any steps/procedures taken to minimize these risks and/or discomforts. Details should also be given of any potential risks to investigators.

There is the possibility that a participant may experience distress in re-visiting a disclosure they have made in therapy, especially if it involves a traumatic or unresolved experience. The focus of the research is not on what was disclosed, but on the process the client went through before, during and after disclosing something that they considered to be significant to the therapist. However, it is possible that this may cause upset to a participant.

14. Ethical issues

What do you consider to be the main ethical issues which may arise during the investigation, and how do you propose to address them (please refer in particular to Code of Practice, section 5.1)

The main ethical issue is that a participant may become distressed after discussing a significant disclosure and/or listening to it again on the tape of the session.

To minimise any distress the participant will be informed at the start of the interview (as well as stated on the Consent Form) that the interview may be terminated at any time. If a participant becomes upset during the interview the researcher or participant will have the option of terminating the interview immediately and support will be provided to the participant.

The researcher will arrange for a counsellor to be available if any participant wishes to speak to a therapist following the interview; if they prefer, the participant can be referred back to their therapist at the Research Clinic.

15. Any payment to be made:

Include reference to reimbursements for time or expenses incurred, plus any additional fee/incentive for participation.

Travel expenses will be paid, as appropriate, but no other payment will be made.

16. What debriefing, if any, will be given to volunteers?

Following the interview, participants will have a full debriefing with the researcher on their experience of the interview and their current well-being. The researcher will arrange for counsellor to be available, should the participant wish to speak to a third party about any issues that may have arisen for them as a result of the interview.

17. What are the expected outcomes of the investigation? How will these be disseminated? Will you seek to publish the results?

It is expected that the research will provide insights into how clients experience disclosing personal information in therapy, what factors facilitate client disclosure and how disclosure affects the successful outcome of therapy.

I will seek to publish the results in a counselling journal e.g. Counselling & Psychotherapy Research, and present the findings at conferences e.g. BACP Counselling Research Conference, COSCA Research Conference.

How long will data (incl. e.g. photographs) be kept, and how will it be stored?

Consent will be sought to keep the data securely in case a follow-up investigation is carried out. Hard data (e.g. Consent Forms) will be stored in locked cabinets and kept separately from other data e.g. interview tapes. All data used in the study will be anonymised. Any data stored on a computer will be anonymised, backed-up and password protected.

18. Nominated person (and contact details) to whom participants' concerns/questions should be directed before, during or after the investigation (in the case of student

projects, both the supervisor (Ord 16 staff member) and the student should be named); in all cases a member of University staff should be named.

Any concerns or questions about the research should be directed to the supervisor of the researcher, Professor Robert Elliott, University of Strathclyde, Jordanhill Campus, 76 Southbrae Drive, Glasgow, G13 1PP .

Tel: 0141 950 3727
E-mail: robert.elliott@strath.ac.uk

Questions may also be directed to the student, Jane Balmforth, c/o University of Strathclyde
Tel: 0781 654 5367
E-mail: jane.m.balmforth@strath.ac.uk

19. Previous experience of the investigator(s) with the procedures involved.
Professor Robert Elliott is a leading researcher in counselling and psychotherapy and is currently Director of the Counselling Research Clinic at the University of Strathclyde. Professor Elliott has developed the methodology, Comprehensive Process Analysis, to be used in this study and has published several papers using the method (e.g. Rees, A., Hardy, G. E., Barkham, M., Elliott, R., Smith, J. A., Reynolds, S. 'It's Like Catching a Desire Before it Flies Away': A Comprehensive Process Analysis of a Problem Clarification Event in Cognitive-Behavioural Therapy for Depression. Psychotherapy Research 11(3) 331-351, 2001.) Professor Elliott also has extensive experience of supervising students carrying out similar research projects.

Jane Balmforth has an MSc in Counselling (University of Strathclyde, 2006). She has carried out a pilot study on archived data using Comprehensive Process Analysis into a client's experience of significant disclosure, under the supervision of Professor Elliott.

20. <u>Generic approval</u>: if approval is sought for several separate investigations, or a series of investigations, all employing the same basic methodology and serving the same overall objective, then generic approval can be sought for a 3-year period. Give, <u>on a separate sheet</u>, further details about additional studies to be covered by this approval application, using the relevant headings (1-17 above), and drawing attention to any variations in methodology, participants, risks, etc. Student projects can also be submitted via Generic approval – see Code of Practice on Investigations on Human Beings, Section 6.3.

21. <u>Sponsorship</u>
This application requires the University to sponsor the investigation. I am aware of the implications of University sponsorship of the investigation and have assessed this investigation with respect to sponsorship and management risk. As this particular investigation is within the remit of the DEC and has no external funding and no NHS involvement, I agree on behalf of the University that the University is the appropriate sponsor of the investigation and there are no management risks posed by the investigation.

If not applicable, cross here

Signature of Head of Department Please also print name below

.....

Date:

22. Declaration

I have read the University's Code of Practice on Investigations on Human Beings and have completed this application accordingly.

Signature of Chief Investigator .... Please also print name below

Signature of Head of Department Please also print name below

....

Date:

* *

Notes

1. If there is any variation to any aspect of the investigation (location, investigators, methodology, risks, etc.) then the Secretary to the Ethics Committee should be notified in writing immediately.

2. Should anything occur during the project which may prompt ethical questions for any similar projects the Chief Investigator should notify the Ethics Committee.

3. Insurance and other approval requirements from appropriate external bodies must also be in place **before** the project can commence.

* *

For applications to the University Ethics Committee this completed form should be sent (electronically, with signed hard copy to follow) to Research and Innovation in the first instance.

You may append further documents by expanding the text box below:

University of Strathclyde
Education

Notice of Departmental Ethics Committee Decision

Date: 27th July 2008

Applicant: Professor R Elliott (Jane Balmforth)

Project Title: How clients experience significant disclosures in therapy.

Approval Of Investigation

The Departmental Ethics Committee confirm ethics approval for the above investigation strictly within the terms as advised on the application.

When your investigation is completed we would welcome a short note indicating completion and advising of any ethical matters that may have arisen but which were not anticipated within your application.

The committee wishes you success in your investigation.

For the Departmental Ethics Committee

pp David Wallace (Chair)

Department of Educational and Professional Studies
Sir Henry Wood Building
76 Southbrae Drive
Glasgow G13 1PP

t: 0141 950 3183/3368
f: 0141 950 3367
www.strath.ac.uk/eps

Mr Clive Rowlands
Head of Department

Appendix K: University of Strathclyde: Practice-based psychotherapy research consent form

Client ID: _____

Strathclyde Centre for Counselling and Psychotherapy
Suite D303 David Stow Building, Jordanhill Campus
University of Strathclyde Counselling Unit
76 Southbrae Drive, Glasgow G13 1PP
Email: enquiries@strathclydetherapy.com
Phone: 0844 586 4560

University of Strathclyde

PRACTICE-BASED PSYCHOTHERAPY RESEARCH

CONSENT FORM (v5; 09/11)

		Please initial box
1.	I confirm that I have read and understand the information sheet dated 09/2011 (v5) for the above study. I have had the opportunity to consider the information, ask questions, and have these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	☐
3.	I understand that relevant data collected during the study may be used by members of the research team at the University of Strathclyde. I understand that I will be asked separately about the use of the recordings of my counselling sessions and research interviews as detailed in the Release of Recordings form dated 09/2011 (v5).	☐
4.	I confirm that I am aged 18 or over and that I am aware of what my participation involves and any potential risks.	☐
5.	I agree to take part in this study	☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher/witness	Date	Signature

When completed, 1 copy for participant, 1 copy for research file

Appendix L: University of Strathclyde: Practice-based psychotherapy research information sheet

PRACTICE-BASED PSYCHOTHERAPY RESEARCH
INFORMATION SHEET (v3; 10.07)

Strathclyde Centre for Counselling and Psychotherapy
Suite D303 David Stow Building
Counselling Unit
University of Strathclyde
Jordanhill Campus
76 Southbrae Drive
Glasgow G12 1PP
0844 586 4560

INVESTIGATORS:

Professor Robert Elliott, PhD, Chief Investigator (0141 950 3727;
Robert.Elliott@strath.ac.uk)
Brian Rodgers, PhD, MSc, PG Dip Counselling, MBACP, Project Coordinator
Professor Mick Cooper, PhD, UKCP
Lorna Carrick, MA(Hons), PG Dip Counselling, MBACP
Elizabeth Freire, PhD
Tracey Sanders, BSc(Hons), PG Dip Counselling, MBACP

INFORMATION FOR PARTICIPANTS

The main goal of this research is to improve our understanding of the effects of Person-Centred / Experiential psychotherapies and what brings about those effects. In Person-Centred and Experiential approaches, therapists or counsellors work actively and respectfully with clients to help them explore their experiences; this enables them to make sense of these and to help them change what they wish to change. This therapy differs from others in that it refrains from giving advice or making interpretations. Other goals of this research are improving the training and effectiveness of counsellors by teaching them how to integrate research into counselling and developing better ways of studying counselling.

If you fit the standard research criteria for this type of study and are willing to take part, you will be offered Person-Centred/Experiential psychotherapy from experienced Counselling Unit staff members, or from closely supervised postgraduate students in counselling or counselling psychology.

- The number of therapy sessions will be determined by you, up to a maximum of 40 sessions.
- In the course of the study, we will ask you to give us information about your therapy, including your perceptions of your problems and how you are functioning, as well as your experience of specific therapy sessions.
- We will ask you to fill out questionnaires, and to be audio and preferably video recorded.
- In addition, after every ten sessions, at the end of treatment, and at six and eighteen month follow up, we will ask you to fill out more questionnaires and be interviewed by a member of the research team.

The point of all this is to help us discover information that may be useful for developing and evaluating Person-Centred and Experiential psychotherapies, and to improve the training of our postgraduate students.

WHAT YOU WILL BE ASKED TO DO: This research involves several stages, all of which will take place in the D303 area of the David Stow Building on the Jordanhill campus of the University of Strathclyde:

1. First, you will take part in a preliminary evaluation session. The main purpose of this session is for us to make sure that the study is appropriate for you and for you to decide whether or not you want to participate.
   - We will ask you some questions about the kinds of problems you are having, first, to make sure that there is not some other condition that indicates the need for a different approach, and second, to help you develop a list of problems you want to work on with your counsellor.
   - We will not be able to see you if you are currently in psychotherapy or counselling elsewhere, or if you are going through current severe substance misuse, active psychotic condition or current domestic violence.
   - You will then be asked to read this information sheet and to sign the consent form. Please read over this information carefully and make sure you understand it; note anything that may be unclear or that may be of concern to you, so you can discuss it with the researcher; do not sign it yet.
   - If you decide you would like to participate and fit our guidelines, you will be asked to sign the consent form, and to complete some additional questionnaires prior to your first therapy session. If not, we will assist you with a referral to another source of help if you wish.

2. In the study, you will work with the therapist or counsellor assigned to you up to a maximum of 40 sessions; the specific amount will be determined by you. You will meet with your therapist or counsellor once each week for 50 minutes.
   - Each of these sessions will be recorded (preferably video recorded but at a minimum audio recorded).
   - Immediately before and after each session, you will be asked to fill out brief questionnaires about how you are doing or about your experience of the session. These questionnaires should take about 10 minutes each week.

The counsellor working with you will do their best to arrive in good time and will not cancel sessions at short notice unless there are circumstances beyond their control. In entering into a counselling contract, you will be asked to commit to attending sessions regularly and to avoid cancelling at short notice wherever possible.

3. After every ten sessions and at the end of therapy, you will meet with a member of the research team, who will interview you about your problems and your experience of therapy, and ask you to complete some additional questionnaires. This should take about 2 hours each time, in addition to your usual therapy session. Finally, if you would like, we can offer optional follow-up evaluations at 6 months and 18 months after therapy ends, each lasting about 2 hours.

POSSIBLE RISKS AND WHAT TO DO ABOUT THEM: Before you consent to take part in this study, we want you to know about the possible risks of doing so, and how you can reduce those risks.

1. Self-consciousness about being recorded. Although most people in the past have been

able to disregard the recording equipment, a few have felt inhibited or self-conscious and have found it difficult to talk about deeply personal matters. If you think being recorded will interfere with your receiving help in therapy, please do not volunteer for this study. Video recording is valuable for research and supervision, but can be dropped if it would interfere with your therapy.

2. Getting bored with all the forms. There are a lot of forms to fill out for this research, and some people find them tedious and boring. Please do not volunteer for this research if you hate filling out forms!

3. Getting worse. Some clients experience temporary emotional discomfort or distress during therapy, including strong emotions. The therapist or counsellor will work actively with you to help you deal with any painful emotions that may surface. If, however, you are seriously concerned about this, you may wish to reconsider volunteering for this study. If you volunteer and problems do occur, please report them to your therapist or counsellor, who will do their best to help address the difficulty. It may even turn out that the counselling is either not helping or, in rare instances, is causing harm; in such cases, it may be necessary to stop counselling or to refer you to a different form of treatment. If, however, you do require immediate additional care, you might have to pay for this.

4. Not getting better. It is also possible that, at the end of your treatment, you may be in need of further therapy. If you feel you need further treatment, you and your therapist or counsellor can discuss possible options. For example, they may offer you a referral to another counsellor, type of therapy, or agency.

Starting counselling can be challenging and we recognise that things can happen that make it seem difficult to carry on with therapy. You are free to leave at any stage. We do, however, stress that it can be helpful for you to take the chance to discuss any difficulties with your counsellor or one of the research team so we can address any problems that you raise directly.

POTENTIAL BENEFITS: In contrast to the risks listed above, there may also be some direct and indirect benefits for you or other people if you choose to take part in this study:

1. As a result of the treatment, you are likely to feel better and less bothered by the problems you have been having. Previous research suggests that the average client experiences significant improvement through this therapy.

2. Previous clients have reported that completing the research questionnaires and interviews helped them to get more out of their treatment. These procedures may also help you learn things about yourself.

3. Finally, you will be helping us better understand how Person-Centred/Experiential therapies work. This will help counsellors and psychotherapists develop better ways of helping other people, and assist us in our training our post graduate students.

CONFIDENTIALITY: We routinely use audio and video recordings for supervision, and in the consent form we are asking for your permission for that. We will separately ask you to give us permission to keep the recordings of your sessions and research interviews for research purposes, including training other therapists. Because it is important for us to protect your confidentiality, we will be taking several precautions.

- First of all, we will be using codes instead of names to identify all of the recordings and questionnaires.
- In addition, we will edit your name and any other identifying information from any transcripts we might make of parts of your sessions.
- The recordings will be stored on a dedicated, password-protected computer server that is not connected to the internet, and back-ups will be stored in locked filing cabinets.
- Only professional-level project staff and closely supervised postgraduate students in counselling and counselling psychology will be allowed to have access to these recordings.

Unless you tell us otherwise, questionnaires and recordings will be separated from your personal details and kept for at least 5 years and as long as there is scientific use by the Chief Investigator and the research team listed above. Questionnaires will be destroyed and recordings will be erased when there is no longer any scientific use of these data. We will review these issues with you after every ten sessions and again at the end.

There are some situations that can arise in which we may have to take action to protect others from harm, and in that have to reveal information that has come to light in interviewing a participant in this study or during counselling sessions. An example is where information was revealed that there was a child being abused by someone. If such a situation arises, we would limit the disclosure to what is necessary. We would also make every effort to fully discuss it with you beforehand before doing that.

QUESTIONS AND CONCERNS: If you have any questions or concerns about any aspect of your therapy or the research, please contact the Research Coordinator at 0844 586 4560 or the Chief Investigator, Professor Robert Elliott, at 0141 950 3727. In addition, you may contact Mrs G McArthur, Secretary to the University Ethics Committee, at 0141 950 2472.

PRACTICAL ISSUES: Strathclyde Centre hours are generally Monday through Friday, 9 AM - 5 PM, with evening hours until 7 PM Monday to Thursday during the University's academic year. The Strathclyde Centre services may be limited when University classes are not in session. It is the client's responsibility to arrive, on time, for all scheduled sessions. If it is necessary to cancel, please do so at least 24 hours before the scheduled session by contacting 0844 586 4561. In most cases, your counsellor or a supervisor will be available by phone within a day or two in case of emergency. Clients experiencing an acute emergency, however, are encouraged to contact their GP, NHS 24: 08454 24 24 24, or the Samaritans 08457 90 90 90.

ONCE YOU HAVE BEEN ACCEPTED INTO THIS STUDY AND HAVE AGREED TO TAKE PART, PLEASE SIGN THE "INFORMED CONSENT AGREEMENT." IF YOU HAVE QUESTIONS ABOUT THE NATURE OF THE STUDY, PLEASE FEEL FREE TO ASK THEM BEFORE SIGNING OR AT ANY TIME. YOU MAY WITHDRAW FROM PARTICIPATION AT ANY POINT WITHOUT PREJUDICE TO YOUR RELATIONSHIP TO THE COUNSELLING UNIT OR THE UNIVERSITY OF STRATHCLYDE.

Appendix M: University of Strathclyde: Practice-based psychotherapy research: Release of recordings consent form

Client ID: _____

Strathclyde Centre for Counselling and Psychotherapy
Suite D303 David Stow Building, Jordanhill Campus
University of Strathclyde Counselling Unit
76 Southbrae Drive, Glasgow G13 1PP
Email: enquiries@strathclydetherapy.com
Phone: 0844 586 4560

University of Strathclyde

PRACTICE-BASED PSYCHOTHERAPY RESEARCH

RELEASE OF RECORDINGS CONSENT FORM (v4; 02/2008)

Once you have finished your counselling, we would like your permission to use the recordings of your research interviews and therapy sessions to help us understand how therapy works. Below are some of the possible situations in which we would like to use these recordings, if you are willing to give us permission to do so.

For each of the situations described below, please indicate whether you agree to this use or not. Please don't agree to anything you feel uncomfortable with. We are asking you to review this form after ten sessions and again at the end of counselling so that you can make changes if you wish to. Please feel free to discuss this with your counsellor and to negotiate with the research assistant about any of these possible uses.

		Please circle one	Please initial box
1.	After counselling is over, I am willing for my counsellor to read the questionnaires and listen to what I said in the research interviews.	NO YES	☐
2.	I am willing for the video and audio recordings of my sessions to be used for training other therapists or counsellors in the present project, for a period of at least 5 years.	NO YES	☐
3.	I am willing for the video and audio recordings of my counselling sessions and research interviews to be used for training other postgraduate level students or other mental health professionals, for a period of at least 5 years or as long as there is a specific use identified by the Chief Investigator or research team.	NO YES	☐
4.	I am willing for the professional members (the investigators, research associates, postgraduate counselling students, and professional consultants) of the research team to analyse the recordings for the purpose of developing and evaluating Person-Centred and Experiential psychotherapies.	NO YES	☐
5.	I am willing for brief excerpts from my counselling sessions and research interviews to be presented at scientific meetings or in scientific publications in order to better understand what the therapeutic process is like for clients. I am willing for these excerpts to take the form of: (please cross out any which you wish to exclude): ◦anonymous transcripts of counselling sessions ◦audio recordings of counselling sessions ◦video recordings of counselling sessions ◦anonymous transcripts of research interviews ◦audio/video recordings of research interviews	NO YES	☐

Please turn over

6. I am willing for research teams at other Universities within the European Union to analyse data from my counselling as long as they are monitored by the Chief Investigator and pledge to protect my identity. This permission includes (please cross any which you wish to exclude):
    - questionnaire data
    - anonymous transcripts of counselling sessions
    - audio recordings of counselling sessions
    - video recordings of counselling sessions
    - anonymous transcripts of research interviews
    - audio/video recordings of research interviews

NO YES ☐

7. I am willing for research teams at Universities outside the European Union, which are not covered by the Data Protection Act, to analyse data from my counselling as long as they are monitored by the Chief Investigator and pledge to protect my identity. This permission includes (please cross any which you wish to exclude):
    - questionnaire data
    - anonymous transcripts of counselling sessions
    - audio recordings of counselling sessions
    - video recordings of counselling sessions
    - anonymous transcripts of research interviews
    - audio/video recordings of research interviews

NO YES ☐

8. I am willing to be contacted if any additional use of the recordings or other data is requested.

NO YES ☐

Please indicate specific identifying information which should be edited from the recordings (e.g. personal names, place names, places of employment or schools):

Please indicate a permanent address and phone number or email address at which you may be contacted:

I understand that, by responding to the above items and signing below, I have given my permission for the video and audio recordings and other data from my sessions and interviews to be used in the manner I have specified.

Name of participant	Date	Signature
Name of researcher/witness	Date	Signature

Appendix N: Researcher's Consent form

University of Strathclyde

How clients experience significant disclosures in therapy
Researcher: Jane Balmforth

CONSENT FORM

By signing the Consent Form I am indicating that

- I am participating voluntarily in this research project
- I understand fully the nature of the project and what is required of me
- All my questions about the research project have been satisfactorily answered
- I may terminate my participation in the project at any time without giving a reason and I may request any information I have given to be destroyed at any time, all without negative consequences for me with the University of Strathclyde or my receiving services from them or any other agent
- I understand that any information I provide will be treated with the utmost confidentiality and my anonymity will be respected at all times

Signed:.....

Name:.....

Date:.....

Contact phone number/e-mail address:.....

.....

Counselling Unit
76 Southbrae Drive
Glasgow G13 1PP

t: 0141 950 3359/3222/3165
f: 0141 950 3329
www.strathclydecounselling.com

Appendix O: Researcher's Information Sheet

University of Strathclyde

How clients experience significant disclosures in therapy

Information Sheet

Thank you for your interest in this research project. This Information Sheet describes in more detail the background and nature of the research.

My name is Jane Balmforth and I am a PhD student at the University of Strathclyde. (Phone: 0781 654 5367 E-mail: jane.m.balmforth@strath.ac.uk)

My research supervisor is Professor Robert Elliott at the University of Strathclyde. (Phone: 0141 950 3727 E-mail: robert.elliott@strath.ac.uk)

Aims of the Research

I am interested in researching the process that clients go through before, during and after they disclose something important to their therapist. I would also like to know more about how disclosing important information affects a client's experience of therapy and affects whether a client feels the therapy has been successful or not.

I hope that by researching what is helpful and hindering for clients in the process of disclosing to their therapist that counsellors can learn how to better understand the client process and thus be more effective.

This project has been approved by the University of Strathclyde Ethics Committee.

Confidentiality

I will ensure confidentiality for all participants in the research project. Your identity and any personal information will be kept confidential at all times. Any information used in the study will be anonymised and treated in accordance with the Data Protection Act (1998) and the University of Strathclyde's Ethical Code of Practice (Fourth Edition, January 2008).

Appendix P: Personal Questionnaire procedure

PERSONAL QUESTIONNAIRE (Interviewer Instructions)

Simplified Personal Questionnaire Procedure (9/01)
Robert Elliott
University of Toledo

The Personal Questionnaire (PQ) is an expanded target complaint measure which is individualized for each client. It is generated from the PQ Problem Description Form, completed by the client during the screening process. It intended to be a list of problems that the client wishes to work on in therapy, stated in the client's own words.

Materials:

4" x 6" Index Cards
Blank PQ Form (for writing in items)
Problem Description Form (completed)

Procedure

1. Generating Items. The items generated for the PQ should be the most important in the client's view. However, an attempt should be made to include one or two problems from each of the following areas:

- •Symptoms
- •Specific performance/activity (e.g., work)
- •Relationships
- •Self-esteem
- •Emotions and inner experiences

This means that if the client does not list a problem in a particular area, the interviewer should ask the client if s/he has any difficulties in that area that s/he wants to work on in therapy. If, however, the client does not wish to have an item for this area, the researcher does not insist on it.

This part of the procedure should be thought of as a brainstorming session, generating as many potential items as possible (around 15 is preferable). If the client has difficulty coming up with 10 problems, the interviewer can use other screening measures as sources of possible problems. For example, if the client has completed the CORE-OM, the interviewer can ask the client about items with "3" or "4" ratings.

2. Refining the PQ items. Next, the interviewer helps the client to clarify his/her items and, if necessary, to rephrase the goals into problems. If necessary, the number of items is reduced to around 10.

2a. In this part of the procedure, the interviewer begins by writing each problem onto a separate index card, revising it in the process. Refining PQ items is not a mechanical procedure, but requires discussion with the client to make sure that the PQ reflects his/her chief concerns. It takes careful, patient communication to make sure that the PQ items truly reflect the client's experience of what is problematic.

PQ items should be present problems or difficulties, and should be worded "I feel," "I am," "I can't," "My thinking," and so on. It is useful to think of the list as things the client wants to change through therapy. A good PQ item has the following characteristics:

(i) It reflects an area of difficulty, rather than a goal (e.g., "I am too shy" rather than "I want to be more outgoing").
(ii) It is something that the client wants to work on in therapy.

(iii) It refers to a specific problem; that is, general, vague problems are specified.
(iv) It refers to a single problem; that is, items referring to multiple problems (e.g., "I'm uncomfortable around other people and have trouble talking about myself.") are divided up into multiple items.
(v) It is in the client's own words, not the interviewer's.
(vi) It is not redundant with another PQ item.

2b. After the interviewer writes down the items, s/he then asks the client if anything has been left out, adding further items as needed, until the client feels that the list is complete.

2c. The interviewer next reviews the items with the client, asking the client to revise or confirm them. If the client has generated more than 10 items, the interviewer asks the client to delete or combine repetitive items. If there are still more than 10 items, the interviewer asks the client is s/he wants to drop any. The interview should not force the client to generate exactly 10 items; but try to obtain 8-12 items where possible.

3. Prioritizing the items. Next, the interviewer asks the client to sort the index cards into order, with the most important concern first, the next most important second, etc. The rank order of the item is written on the card.

4. Rating the PQ. After prioritizing, the interviewer gives the client a blank PQ form and the rank-ordered index cards, and asks the client to use the blank form to rate how much each problem has bothered him/her during the past week. These ratings become the client's initial baseline score for the PQ.

5. Duration ratings. In addition, at this first administration of the PQ, the interviewer may want to find out how long each problem has bothered the client at roughly the same level or higher as it does now, using the Personal Questionnaire Duration Form. This can be useful for establishing a retrospective baseline for the PQ.

6. Prepare the PQ. Finally, the interviewer types or writes the PQ items onto a blank PQ form, making at least 10 copies for future use. In doing so, it is a good idea to leave 2 spaces blank for the client to add more items later, in case his/her problems shift over time.

7. Adding items. Clients may add items to their PQs, either on a temporary basis, by writing them in the space at the bottom on the form, or permanently, by requesting that the item be added to the printed form.

Appendix Q: Frequency Analysis: Complete list of themes

Cross-analysis table

CPA domain	Category/subcategory	Frequency	Examples from data
Background Context **Conflict schemes**	Attachment-based wishes	General (6/7)	Client wants acceptance, fears being criticised (Anna). Client wants affection, fears rejection (Carrie).
	Autonomy-based wishes	Variant (3/7)	Clients wants to be responsible, fears letting people down (Tom). Client wants to achieve, fears failure (Lucy).
Self-schemes	Positive self-schemes	Typical (5/7)	Self as responsible person (Maggie). Self as strong person who helps others, doesn't need help himself (Tom).
	Negative self-schemes	Typical (4/7)	Self as airhead, thick (Lucy). Self as useless, inadequate (Carrie).
Client Style	Open, articulate, engaging style	Typical (4/7)	Tom, Maggie, Carrie and Julia.
	Reflective, thoughtful, intellectual style	Variant (2/7)	Anna, Carrie.
	Avoid revealing feelings	Variant (2/7)	Lucy reveals in BSR she felt tearful at disclosure but concealed it at the time; Rosa is wary about accessing feelings about ex-partner.

Client Problems	Lack of self-confidence and self-esteem	General (7/7)	'I need to have more confidence in my own ability' (Lucy). 'I had goals before and things went wrong and I lost my confidence (Rosa).
	Health issues.	Typical (5/7)	Eating disorder (Lucy); depression (Maggie and Anna); anxiety (Tom), PTSD (Julia).
	Strong internal critic.	Typical (4/7)	'I'm quite critical of myself' (Anna). 'I need to say 'give yourself a break' (Lucy).
Client Situation	Difficulty in significant relationships (children, partner, parent).	General (6/7)	Maggie, Rosa and Carrie had problems with partners; Maggie also with her daughter and granddaughter; Lucy and Julia had difficult relationships with their mothers; Anna was getting a divorce.
	Demanding, stressful job.	Typical (5/7)	Tom: stress over job triggers anxiety; Maggie: sick-leave due to work-related stress; Anna: self-employed, stressful to keep getting work; Lucy and Carrie: have challenging jobs.
Client History	**Childhood development issues**	Typical (4/7)	Carrie, Anna, Maggie and Julia.
	Strict upbringing and lack of parental affection.	Variant (3/7)	Carrie, Anna and Maggie.
	Suffered sexual abuse.	Variant (2/7)	Julia and Carrie.
	Earlier wild behaviour (sex, drugs), suffered rape and attempted murder.	Unique (1/7)	Julia.

	Adult difficulties	General (6/7)	Carrie, Julia, Rosa, Maggie, Anna, Lucy.
	Unsatisfactory relationships with male partners.	Typical (4/7)	Carrie, Julia and Rosa: treated badly in relationships; Maggie suffered domestic violence; Anna manipulated and criticised.
	Worked in difficult environment where couldn't be self.	Variant (2/7)	Anna worked in male-dominated environment; Lucy worked in image-conscious environment.
	Previous experience of therapy	Typical (5/7)	Anna, Lucy, Carrie, Rosa and Maggie.
	Previous helpful experience of therapy.	Typical (4/7)	Anna, Lucy, Carrie and Rosa.
	Previous unhelpful experience of therapy.	Unique (1/7)	Maggie.
Therapist Personal Characteristics	**Gender**		
	Female	General (6/7)	
	Age	General (6/7)	
	Younger than client	Typical (4/7)	
	Similar age to client	Variant (2/7)	Anna, Maggie, Rosa and Lucy
	Older than client	Unique (1/7)	Tom and Carrie
	Experience as therapist	General (6/7)	Julia
	Inexperienced (less than 2 years)	Typical (5/7)	Anna, Tom, Maggie, Lucy and Rosa
	Four years' experience	Unique (1/7)	Carrie
	Considerable experience	Unique (1/7)	Julia

Therapist Treatment Principles	Person-centred therapy: Core conditions	General (7/7)	Reflecting the client's experience (Lucy); non-judging (Rosa); offering client space to develop own understanding (Anna); using focusing to deepen/clarify puzzling experiences (Carrie).
	Offer CBT techniques	Unique (1/7)	Tom
Pre-session Context **Extra-therapy events**	Clients testing themselves.	Variant (2/7)	Tom tests his anxiety levels by driving; Julia tests her fear by going to a festival.
	External events triggered disclosure.	Variant (2/7)	Lucy's night out with colleagues and Rosa's night out with friend.
	Thinking about previous session.	Unique (1/7)	Anna has been thinking about the session.
	Recent experience of drawing picture of self.	Unique (1/7)	Maggie.
Previous Sessions	Clients planned disclosures in advance.	General (6/6)	
	Disclosure planned since intake (brought to therapy).	Typical (3/6)	Tom: 'It was a case of realising at the point when I first picked up the phone that at some point I'm going to need to tell somebody' (BSR: P22).
	Disclosure planned during therapy (emerged).	Typical (3/6)	Rosa: 'I couldn't get round it, I couldn't not say it' (BSR: P14).

Session Context			
Client Session Task	Explore issues further	Typical (5/7)	Explore new awareness (Anna); explore where he had got to in therapy (Tom); explore confused feelings about intimacy (Carrie); explore ambivalence about on-hold relationship (Rosa).
	Describe recent life events	Variant (3/7)	Treatment at work that has led to illness (Maggie); Story of puzzling 'dip' and relation to academic ability (Lucy); Update therapist about job, house and unexpected meeting (Rosa).
	Disclose puzzling reaction	Unique (1/7)	Carrie revealed in BSR this was a session task carried over from previous session.
Therapist Session Task	Help client explore issues.	Typical (4/7)	'Fear blob' (Julia); confusion about intimacy (Carrie); Lack of confidence (Lucy); disclosure (Anna).
	Support client by listening.	Variant (2/7)	Maggie and Rosa
	Teach CBT techniques and support client in applying them.	Unique (1/7)	Tom
	Follow the client's lead in the session	Unique (1/7)	Lucy
	Develop the therapeutic alliance	Unique (1/7)	Maggie
Alliance	**Alliance: Bond Aspect**		
	Warm, close bond with therapist.	Typical (5/7)	Maggie, Rosa, Tom, Carrie and Julia.
	Doubts that therapist could understand	Typical (4/7)	Maggie, Anna, Rosa and Lucy.

	issues due to younger age. **Alliance: Task Aspect** Clients and therapists worked well on Session and Episode Tasks. Clients did not go deeper into feelings.	Typical (5/7) Variant (2/7)	Anna, Tom, Carrie, Maggie and Julia. Lucy and Rosa.
Session relevant events	Approached disclosure via related content. Discussed unrelated topic (avoiding disclosure). No session relevant events.	Typical (4/7) Variant (2/7) Unique (1/7)	Lucy talked about a dip in confidence; Tom discussed changing a PQ item; Carrie described feeling a block in intimacy with partner; Julia worked on 'blob' of fear and pain. Maggie talked fluently and at length about work; therapist made few interventions; Rosa spent first eight minutes of session deciding whether/when to disclose. Anna: Disclosure is at start of session.
Episode Context Client Episode Task	Make a decision. Communicate feelings about a closely related topic.	General (6/7) Unique (1/7)	Decide to trust the therapist (Maggie); Decide to disclose (Rosa, Tom, Carrie, Julia); Disclose link to the past and memories of her father (Maggie). Julia: 'I think people would be surprised...'
Therapist Episode Task	Support client to disclose and help client explore disclosure.	General (7/7)	Listen empathically (Anna, Carrie); Show understanding (Anna, Carrie, Tom); Help client silence potentially interfering inner critic (Maggie,

			Lucy); Follow client lead on topics presented (Lucy, Rosa and Carrie); Help client make connections between early and later victimisation (Julia).
	Explore with client if needs to work on disclosed abuse	Unique (1/7)	'what do you wanna do with this?' (Julia's therapist).
	Suggest cognitive strategy.	Unique (1/7)	'If we were gonna look down the whole kind of CBT thing then what I would maybe be asking you to do is, get yourself into a situation where you feel that way...' (Tom's therapist).
Episode Relevant Events	Extra-therapy events related to disclosure.	Typical (4/7)	Story of night out (Lucy); Upset about intimacy difficulties (Carrie); Ran out of decoy material (Rosa); Described wild behaviour at school (Julia).
	Within-session events related to disclosure.	Variant (3/7)	Therapist hunched and moving in chair reminded client of father (Maggie); Tom wanted to use CBT techniques to test himself; Julia explored the 'fear blob'.
	Therapist suggests CBT approach.	Unique (1/7)	'maybe when you <u>have</u> one of these situations notice what your thoughts are and then try and think of more like helpful alternative thoughts...' (Tom).
	No episode relevant events	Unique (1/7)	Anna (start of session).
Local Cue	Therapist questions	Typical (4/7)	
	a. Focusing questions.	Variant (3/7)	'What are the thoughts that come after that?' (Tom); 'Is there something about not valuing

			yourself?' (Maggie); 'Were you?' (Julia).
	b. Opening session question.	Unique (1/7)	'What would you like to talk about today?' (Anna).
	Client narrative leading up to the disclosure.	Variant (2/7)	'I was out last night....' (Lucy); '[partner] and I met two years ago yesterday ...' (Rosa).
	Pause that allowed client to disclose.	Unique (1/7)	'Shall I say it? I'm just gonna say it' (Carrie).

Process

CPA domain	Category	Frequency	Examples from data
Process **Response Mode**	Self-disclosure	General (7/7)	
	a. Self-disclosure: Respond to therapist's question.	Typical (4/7)	Respond to therapist's 'fit' question (Julia). Respond to therapist's opening question at start of session (Anna). Respond to therapist's open question (Tom). Respond to therapist's empathic, refocusing question (Maggie).
	b. Self-disclosure: Self-initiate a new topic.	Variant (3/7)	Begin a self-initiated narrative (Lucy, Rosa). Make announcement in middle of session (Carrie).
	Response Task Reveal something to therapist.	General (7/7)	See Content below
	Continue on track towards clarifying painful feelings.	Unique (1/7)	Julia
Content	'Delicate' topic.	Typical (5/7)	Reveal worst fear (Tom); reveal a recent important event (Rosa); disclose a shameful belief about self (Lucy); reveal abuse (Julia); reveal intimacy issue (Carrie).

	Painful memory. New awareness.	Unique (1/7) Unique (1/7)	Maggie. Anna.
Style/State	Hesitant, tentative speech while disclosing. Fluent, emphatic speech while disclosing. Range of emotionally aroused states. a. Embarrassed. b. Emotional and tearful. c. Surprised. d. Confused. e. Physically tense and uncomfortable.	General (6/7) Unique (1/7) General (7/7) Typical (5/7) Typical (4/7) Variant (2/7) Unique (1/7) Unique (1/7)	Anna, Lucy, Tom, Maggie, Rosa and Julia. Carrie. Lucy, Rosa, Tom, Carrie and Julia. Maggie, Lucy, Julia and Carrie. Anna and Julia. Carrie. Carrie.
Quality	Clients working moderately well or better.	General (7/7)	

Effects

CPA domain	Category/subcategory	Frequency	Examples from data
Effects: Immediate Effects	Painful emotion following disclosure.	General (6/7)	
	a. Sadness	Typical (5/7)	Carrie, Maggie, Lucy, Julia, Anna.
	b. Embarrassment, shame	Variant (3/7)	Tom, Rosa, Carrie.
	c. Pain for self and others.	Unique (1/7)	Julia.
	Confusion, puzzlement.	Variant (2/7)	Carrie and Lucy.
	Support from therapist enabled clients to put aside discomfort and explore issue.	Typical (4/7)	Julia, Carrie, Tom, Maggie.
	No immediate support from therapist, client distanced self.	Variant (3/7)	Lucy, Anna, Rosa.
Within-Episode Effects (Quantitative) (CEXP)	Modal depth of experiencing rose or stayed same from 1 min pre to disclosure.	General (6/6)	
	Peak depth of experiencing rose between 1 min pre and disclosure	Typical (4/6)	
	Modal and Peak depth of feeling rose or stayed same from event to 1 min post disclosure.	General (6/7)	

Within-Session Effects	Client spoke about other topics and returned intermittently to disclosure topic. Significant disclosure became focus for rest of session. Did not focus on topic after disclosure.	Variant (3/7) Variant (3/7) Unique (1/7)	Anna, Lucy, Rosa. Tom, Carrie and Julia. Maggie.
Post-session Effects: **Immediate Post-session Effects (Qualitative)**	At end of session, clients reported positive feelings about session. Client worried that therapist would think less of her after disclosure.	General (6/7) Unique (1/7)	 Rosa.
Immediate post-session Effects **(Quantitative)**	Clients rated the disclosure as greatly or extremely significant. Clients rated the helpfulness of the disclosure as at least moderately helpful.	General (6/6) General (5/6)	 Rosa did not wish to rate the helpfulness of the disclosure
Post-session Effects **(Quantitative)**	Clients rated session as moderately helpful or better. PQ pre-post disclosure ratings were unchanged.	General (7/7) General (6/6)	
Extra-therapy Effects	Feeling unambivalently positive about session and this feeling lasted. a. Felt relief b. Felt optimistic about the course of therapy	General (5/6) Typical (3/6) Variant (2/6)	 Tom, Carrie and Lucy Tom and Carrie.

	c. Exploration useful Feeling of euphoria and then a delayed negative reaction.	Variant (3/6) Unique (1/6)	Lucy, Anna and Rosa. Maggie.
Subsequent Sessions	Discussed disclosure in at least one subsequent session of therapy. a. Returned to topic pervasively. b. Returned to topic sporadically. Did not return to topic.	General (6/7) Typical (4/7) Variant (2/7) Unique (1/7)	 Anna, Maggie, Lucy and Rosa. Julia and Carrie. Tom.
Post-therapy Effects: **Post-therapy-effects (Qualitative)**	**End of therapy interview** Disclosure still significant. Client distanced self from disclosure. **Six and 18 month follow-up interview** Disclosure still significant; issue resolved. Client distanced self from disclosure; issue unresolved.	 General (4/5) Unique (1/5) General (4/5) Unique (1/5)	 Anna, Tom, Maggie and Lucy. Carrie. Anna, Tom, Maggie and Lucy. Carrie.
Post-therapy Effects: **Post-therapy-effects**	**Significance of disclosure** Clients rated the disclosure as very or	 General (5/6)	 Anna, Tom, Lucy, Maggie and Rosa.

(Quantitative)	extremely significant throughout therapy. **Helpfulness of disclosure** Helpfulness rating decreased to end of therapy/follow-up.	Typical (3/6)	Carrie, Lucy and Rosa.
Outcome Effects	Clients reported less distress between intake and end of therapy on two out of three instruments (CORE-OM and SI).	Typical (4/6)	CORE-OM: Anna, Carrie, Maggie and Rosa improved from clinical to non-clinical range pre-post therapy. Tom and Lucy were not clinical to start with. SI: Anna, Carrie, Maggie and Rosa improved from clinical to non-clinical range pre-post therapy. Tom was not clinical to start with; Lucy improved but was still in clinical range.

Appendix R: Expectations Analysis: Table of themes and ratings

	List of themes with frequency ratings and expectancy ratings		
	The rating points:		
	3 - this theme was clearly expected (obvious)		
	2 – this theme now appears expectable but was not obvious		
	1 – this theme was not expected but not unexpected either (not really surprising)		
	0 – this theme is unexpected or even surprising		
	G=general theme T=typical theme V=variant theme U= unique theme		
			consensus
1	**Context:** Conflict schemes: attachment-based wishes	G	2
2	Conflict schemes: autonomy-based wishes	V	1
3	clients' positive self-schemes	T	1
4	clients' negative self-schemes	T	3
5	clients' style - articulate, open and engaging	T	1
6	clients' style - reflective, thoughtful, intellectual	V	1
7	Clients' style - avoid revealing feelings	V	2
8	Lack of self-confidence and self-esteem was limiting life	G	2
9	clients have current health issues	T	1
10	clients have strong internal critic	T	1
11	clients were experiencing difficulty in relationships with significant people in	G	3
12	client working in a demanding, stressful job	T	1
13	Childhood developmental issues	T	3
14	Cs had a strict upbringing and a lack of demonstrated affection from parents	V	1
15	sexual abuse	V	1
16	Earlier wild sexual behaviour; suffered rape and attempted murder	U	1
17	Difficulties in adulthood	G	2
18	Client history of unsatisfactory relationships with male partners	T	2
19	C worked in environment where couldn't be self	V	1
20	Previous experience of therapy	T	1
21	Cs found previous therapy to be helpful	T	2
22	Cs found previous therapy unhelpful	U	1
23	therapists were female	G	2
24	Age of therapist	G	0
25	therapists were younger than their clients	T	2
26	therapists were a similar age (within 5 years)	V	1
27	therapist was older than the client	U	1
28	Experience as a therapist	G	1
29	therapists were inexperienced (less than 2 years' experience)	T	2
30	therapist had four years' experience	U	1
31	therapist had considerable experience	U	1
32	therapists worked to core conditions of person-centred therapy	G	3
33	therapist offered CBT techniques	U	1
34	clients had engaged in activities to test themselves (levels of fear and anxiety)	V	2
35	clients had been out with friends and the events triggered the disclosure	V	1
36	client had been thinking about the previous session	U	1
37	client drew picture of self	U	1

38	Clients planned in advance to make the significant disclosure	G	0
39	Disclosure planned since intake (brought to therapy)	T	0
40	Disclosure planned during therapy (emerged)	T	1
41	C Session Task: Explore issues further	T	3
42	Describe recent life events	V	3
43	Disclose puzzling reaction	U	1
44	T session task: help the client explore issues	T	3
45	Support the client by listening	V	3
46	Teach CBT techniques and support the client in applying these	U	1
47	Follow client's lead in session	U	3
48	Develop therapeutic alliance	U	3
49	clients developed a warm, close bond with the therapist	T	3
50	C doubts that the therapist could understand the issues they brought to therapy	T	0
51	Clients and therapists worked well together on the Session and Episode tasks	T	3
52	clients did not go deeper into feelings	V	1
53	Session relevant events: Clients approached disclosure via related content	T	2
54	Clients discussed unrelated topic at length (avoiding disclosure)	V	1
55	No session relevant events	U	0
56	C Episode Task - make a decision	G	1
57	Communicate feelings about a closely related topic	U	2
58	T Episode Task - support the client and help the client explore the disclosure	G	3
59	Explore with client if needs to work on abuse	U	1
60	Suggest cognitive strategy	U	1
61	Relevant events - extra-therapy events related to disclosure	T	2
62	Within-session events related to disclosure	V	2
63	Therapist suggests CBT approach	U	1
64	No Episode relevant events	U	0
65	Local cue - therapist questions	T	2
66	Therapist uses focusing questions	V	1
67	Therapist opens the session with question	U	3
68	Client narratives, leading up to the Disclosure	V	3
69	Pause that allowed the client to make the decision to disclose	U	2
70	**Process:** Response mode: self-disclosure	G	3
71	respond to the therapist's question	T	2
72	Self-initiate a new topic	V	2
73	response task - reveal something to the therapist	G	3
74	to continue on the track towards clarifying painful feelings	U	1
75	Content - a 'delicate' issue	T	3
76	Revealing a painful memory and opening up an emotional reaction	U	2
77	Revealing a new awareness	U	1
78	Style: clients spoke tentatively or hesitantly while making the significant discl	G	2
79	Style: clients spoke fluently and emphatically while making the significant dis	U	0
80	State: clients reported feeling a range of emotions while disclosing	G	3
81	Clients felt embarrassed	T	3
82	Clients were emotional and tearful	T	2
83	Clients felt surprised	V	1
84	Clients felt confused	U	2
85	Clients felt physically tense and uncomfortable	U	2

86	Clients were judged to be working at least moderately well	G	2
87	**Effects:** clients felt some form of painful emotion immediately following the (	G	3
88	Sadness	T	1
89	Embarrassment/shame	V	2
90	Clients felt pain for self and others	U	1
91	Cs felt Confusion, puzzlement	V	1
92	Therapist offered support for disclosure, client felt understood and able to exp	T	2
93	Therapist did not offer support for disclosure, client distanced self and returne	V	1
94	Clients' CEXP modal ratings stayed the same or rose from one minute before	G	2
95	The Peak CEXP rose between 1 min pre event and disclosure	T	2
96	Modal and Peak ratings rose or stayed the same from event to one minute post	T	0
97	Clients spoke about other topics and at times returned intermittently to explore	V	2
98	The significant disclosure became the focus of the rest of the session	V	1
99	client did not return to the disclosure topic again in the session after the event	U	1
100	clients reported positive feelings about the session they had just completed	G	1
101	client was worried that the therapist had thought less of her after the disclosure	U	1
102	the clients rated the disclosure as 'greatly' or 'extremely significant'	G	3
103	Clients rated the helpfulness of the event as at least 7 or 'moderately helpful'	G	2
104	Clients rated the session as at least moderately helpful	G	2
105	client PQ pre-post scores did not show significant change	G	1
106	clients reported feeling unambivalently positive after the session in which they	G	1
107	Felt relief	V	3
108	Felt optimistic about therapy	V	2
109	Exploration took place	V	3
110	client reported an initial feeling of euphoria and then a delayed negative reacti	U	1
111	Clients discussed the disclosure in at least one subsequent session of therapy	G	3
112	Clients returned to the disclosure topic pervasively throughout the rest of thera	T	1
113	Clients returned to the disclosure topic sporadically in later sessions of therapy	V	3
114	client did not refer explicitly to the disclosure topic again	U	1
115	clients described the disclosure as significant at end of therapy	G	2
116	the client distanced herself from the disclosure	U	0
117	6 + 18 month f-up: clients still felt positive about the disclosure, felt that the d	G	2
118	6 month f-up: client still wished to distance herself from the disclosure and it v	U	0
119	The Disclosure significance rating stayed v or extr significant throughout ther	G	1
120	Helpfulness ratings of the disclosure decreased over therapy and follow-up	T	2
121	Clients reported less distress on two out of three instruments	T	2
	Discoveries		
1	clients' positive self-schemes	T	
2	clients' style - articulate, open and engaging	T	
3	clients have current health issues	T	
4	clients have strong internal critic	T	
5	client working in a demanding, stressful job	T	
6	Previous experience of therapy	T	
7	Age of therapist	G	
8	Experience as a therapist	G	
9	Clients planned in advance to make the significant disclosure	G	

10	Disclosure planned since intake (brought to therapy)	T	
11	Disclosure planned during therapy (emerged)	T	
12	C doubts that the therapist could understand the issues they brought to therapy	T	
13	C Episode Task - make a decision	G	
14	Sadness	T	
15	Modal and Peak ratings rose or stayed the same from event to one minute post	T	
16	clients reported positive feelings about the session they had just completed	G	
17	client PQ pre--post scores did not show significant change	G	
18	clients reported feeling unambivalently positive after the session in which they	G	
19	Clients returned to the disclosure topic pervasively throughout the rest of thera	T	
20	The Disclosure significance rating stayed v or extr significant throughout ther	G	
	Confirmed Expectations		
1	**Context:** Conflict schemes: attachment-based wishes	G	
2	clients' negative self-schemes	T	
3	Lack of self-confidence and self-esteem was limiting life	G	
4	clients were experiencing difficulty in relationships with significant people in	G	
5	Childhood developmental issues	T	
6	Difficulties in adulthood	G	
7	Client history of unsatisfactory relationships with male partners	T	
8	Cs found previous therapy to be helpful	T	
9	therapists were female	G	
10	therapists were younger than their clients	T	
11	therapists were inexperienced (less than 2 years' experience)	T	
12	therapists worked to core conditions of person-centred therapy	G	
13	C Session Task: Explore issues further	T	
14	T session task: help the client explore issues	T	
15	clients developed a warm, close bond with the therapist	T	
16	Clients and therapists worked well together on the Session and Episode tasks	T	
17	Session relevant events: Clients approached disclosure via related content	T	
18	T Episode Task - support the client and help the client explore the disclosure	G	
19	Relevant events - extra-therapy events related to disclosure	T	
20	Local cue - therapist questions	T	
21	**Process:** Response mode: self-disclosure	G	
22	respond to the therapist's question	T	
23	response task - reveal something to the therapist	G	
24	Content - a 'delicate' issue	T	
25	Style: clients spoke tentatively or hesitantly while making the significant discl	G	
26	State: clients reported feeling a range of emotions while disclosing	G	
27	Clients felt embarrassed	T	
28	Clients were emotional and tearful	T	
29	Clients were judged to be working at least moderately well	G	
30	**Effects:** clients felt some form of painful emotion immediately following the	G	
31	Therapist offered support for disclosure, client felt understood and able to exp	T	
32	Clients' CEXP modal ratings stayed the same or rose from one minute before	G	
33	The Peak CEXP rose between 1 min pre event and disclosure	T	
34	the clients rated the disclosure as 'greatly' or 'extremely significant'	G	

35	Clients rated the helpfulness of the event as at least 7 or 'moderately helpful'	G	
36	Clients rated the session as at least moderately helpful	G	
37	Clients discussed the disclosure in at least one subsequent session of therapy	G	
38	clients described the disclosure as significant at end of therapy	G	
39	6 + 18 month f-up: clients still felt positive about the disclosure, felt that the d	G	
40	Helpfulness ratings of the disclosure decreased over therapy and follow-up	T	
41	Clients reported less distress on two out of three instruments	T	
	Disconfirmed Expectations		
1	Clients' style - avoid revealing feelings	V	
2	clients had engaged in activities to test themselves (levels of fear and anxiety)	V	
3	Describe recent life events	V	
4	Support the client by listening	V	
5	Follow client's lead in session	U	
6	Develop therapeutic alliance	U	
7	Communicate feelings about a closely related topic	U	
8	Within-session events related to disclosure	V	
9	Therapist opens the session with question	U	
10	Client narratives, leading up to the Disclosure	V	
11	Pause that allowed the client to make the decision to disclose	U	
12	Self-initiate a new topic	V	
13	Revealing a painful memory and opening up an emotional reaction	U	
14	Clients felt confused	U	
15	Clients felt physically tense and uncomfortable	U	
16	Embarrassment/shame	V	
17	Clients spoke about other topics and at times returned intermittently to explore	V	
18	Felt relief	V	
19	Felt optimistic about therapy	V	
20	Exploration took place	V	
21	Clients returned to the disclosure topic sporadically in later sessions of therapy	V	
	Null findings		
1	Conflict schemes: autonomy-based wishes	V	
2	clients' style - reflective, thoughtful, intellectual	V	
3	Cs had a strict upbringing and a lack of demonstrated affection from parents	V	
4	sexual abuse	V	
5	Earlier wild sexual behaviour; suffered rape and attempted murder	U	
6	C worked in environment where couldn't be self	V	
7	Cs found previous therapy unhelpful	U	
8	therapists were a similar age (within 5 years)	V	
9	therapist was older than the client	U	
10	therapist had four years' experience	U	
11	therapist had considerable experience	U	
12	therapist offered CBT techniques	U	
13	clients had been out with friends and the events triggered the disclosure	V	
14	client had been thinking about the previous session	U	
15	client had dream about being forced into situation at work	U	
16	Disclose puzzling reaction	U	

17	Teach CBT techniques and support the client in applying these	U	
18	clients did not go deeper into feelings	V	
19	Clients discussed unrelated topic at length (avoiding disclosure)	V	
20	No session relevant events	U	
21	Explore with client if needs to work on abuse	U	
22	Suggest cognitive strategy	U	
23	Therapist suggests CBT approach	U	
24	Therapist uses focusing questions	V	
25	No Episode relevant events	U	
26	to continue on the track towards clarifying painful feelings	U	
27	Revealing a new awareness	U	
28	Style: clients spoke fluently and emphatically while making the significant dis	U	
29	Clients felt surprised	V	
30	Clients felt pain for self and others	U	
31	Cs felt Confusion, puzzlement	V	
32	Therapist did not offer support for disclosure, client distanced self and returne	V	
33	The significant disclosure became the focus of the rest of the session	V	
34	client did not return to the disclosure topic again in the session after the event	U	
35	client was worried that the therapist had thought less of her after the disclosure	U	
36	client reported an initial feeling of euphoria and then a delayed negative reacti	U	
37	client did not refer explicitly to the disclosure topic again	U	
38	the client distanced herself from the disclosure	U	
39	6 month f-up: client still wished to distance herself from the disclosure and it	U	