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Person Centred and Experiential Psychotherapy Scale (PCEPS): Development and reliability of an adherence/competence measure for person-centred and experiential psychotherapies[1]

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Abstract

Aims: This study aimed to assess the reliability of the Person Centred and Experiential Psychotherapy Scale (PCEPS), a new adherence/competence measure of person-centred and experiential psychotherapies. The PCEPS consists of 15 items with two subscales: *Person Centred Process*, and *Experiential Process*.
Method: One-hundred twenty audio-recorded segments of therapy sessions were rated independently by two teams of three raters using the PCEPS. Half of the segments were 10 min long and the other half were 15 min long. Six therapists were experienced therapists and four were counsellors in training. Seven of the therapists identified their work as 'person-centred', and three identifed their work as 'process-experiential'. Three raters were qualified and experienced person-centred therapists and three raters were person-centred counselling trainees in their first year of training.
Results: Interrater reliabilities were good (alpha: .68 - .86), especially when ratings were averaged across items (alpha: .87); interitem reliabilities were quite high (alpha: .98). Exploratory factor analyses revealed a 12-item facilitative relationship factor that cuts across Person-centred and Experiential subscales (alpha: .98), and a nonfacilitative directiveness factor (3 items, alpha: .89).
Conclusions/Implications: The PCEPS has potential for use in RCT research as well as in counselling training and supervision, but will require further testing and validation.
Key-words: *adherence/competence; person-centred therapy; experiential therapy; measure development*

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Person Centred and Experiential Psychotherapy Scale (PCEPS): Development and reliability of an adherence/competence measure for person-centred and experiential psychotherapies

The assessment of treatment integrity is an essential component of psychotherapy trials (Waltz, Addis, Coerner, & Jacobson, 1993). Tests of treatment integrity have typically included assessment of both adherence and competence, that is, whether therapists accurately followed the therapy manual and also whether they did so in a competent manner. More specifically, Waltz et al. (1993) applied the term *adherence* to refer to the extent to which a therapist used interventions prescribed by the treatment manual and avoided the use of interventions proscribed by the manual, proposing the term *competence* for the level of ability shown by the therapist in performing the therapy. According to these definitions, "competence presupposes adherence, but adherence does not necessarily imply competence" (p. 620). Waltz et al. (1993) also recommended that treatment integrity checks be undertaken through analysis of audio or video recordings of the therapy sessions by independent researchers/practitioners.

In the field of person-centred therapy, the first measures used to assess the competence of person-centred therapists were the Truax *Scales for Therapist Accurate Empathy, Nonpossessive Warmth, and Genuineness* (Truax & Carkhuff, 1967). These scales were designed for the analysis of either live observations or taped recordings of therapy sessions. The Accurate Empathy (AE) scale is a nine-point annotated and anchored rating scale, while the Non-possessive Warmth (NW) and Genuineness (G) scales are both five-point annotated and anchored rating scales. The range of inter-rater reliability values (Pearson's *r*) reported for the AE, NW, and G scales were .43-.79, .48-.84, and .4-.62, respectively; the median alpha reliability values for ratings combined across raters were .95, .77, and .72, respectively (Truax & Carkhuff, 1967). Although the Truax scales became the most well-known and most used observational instrument in the investigation of the Rogerian relationship conditions (i.e., empathy, unconditional positive regard, and congruence) in process-outcome research, widespread dissatisfaction in the field later developed regarding the validity and other psychometric properties of these scales (e.g., Lambert, DeJulio, & Stein, 1978).

Wilczynksi, Brodley, and Brody (2008) also criticized the Truax scales for failing to assess the therapist's nondirective intentions and attitudes. Consequently, they developed a new client-centred rating system that took this dimension into account: the *Nondirective Client-Centered Rating System*. This instrument was initially developed by Brodley and Brody (1990) for study of the psychotherapy sessions conducted by Carl Rogers that were available through audio and video recordings, film, and transcripts. The primarily aim of this scale was to distinguish therapist nondirective intentions or attitudes from directive ones. The mean percentage of agreement between raters in the latest version of this instrument was been reported as 90% (Wilczynksi, Brodley, & Brody, 2008); unfortunately, the authors failed to report the reliability values using standard statistics (i.e., Cohen's kappa). In addition, another deficiency of the instrument is that it only assesses therapist adherence to nondirective person-centred therapy, not their competence.

In a review of the existing measures of therapist empathy, Watson and Prosser (2002) concluded that all fail to capture the complexity of Rogers' definition of empathy. For that reason, they developed an observer-rated measure of therapist empathy that was based on behavioural correlates of empathy identified in previous research: therapists' verbal and non-verbal behaviours, speech characteristics, and response modes. Their *Measure of Expressed Empathy* (MEE) consists of 22 items rated on a nine-point

frequency Likert scale. Watson and Prosser (2002) reported an interrater reliability (Pearson's *r*) of .84 and an inter-item reliability (Cronbach alpha) of .88. These results indicate that the scale can be reliably rated and is internally consistent. (Decker, NIch, Carroll & Martino, 2013, have recent published results using a revised, shortened version of the MEE.) However, the items of the MEE do not to tap into the nondirective aspects of the therapists' responses, which is an essential component of the classical view of person-centred therapy (e.g. Merry, 2004; Raskin, 1947/2005). Therefore, the MEE has limits as an integrity check in efficacy trials of person-centred therapy.

This absence of a good adherence/competence measure of person-centred therapy was probably the reason why in a recent randomized controlled trial on the effectiveness of person-centred counselling in primary care (Ward et al., 2000), no specific rating of the quality of the person-centred counselling was undertaken. The absence of demonstrations that therapy was carried out as intended is an important limitation of studies such as Ward et al., and leaves open questions about what therapists actually did in such studies, and whether their practice was truly within a person-centred or experiential approach, as well how nondirective or process guiding the therapists were.

In view of the absence of an appropriate adherence/competence measure of person-centred therapy and given the fundamental importance of this kind of measure in the development of efficacy trials for person-centred therapy, we developed a new instrument to fill that gap: the *Person-Centred and Experiential Psychotherapy Scale* (PCEPS). In the present report we focus on the assessment of the reliability of the PCEPS. To what extent did raters agree with one another in their ratings on the PCEPS?

Method

Measure Development and Piloting

For the development of items for the PCEPS, the first two authors, EF and RE, used as starting point some items of the Measure of Expressed Empathy (MEE) and the Nondirective Client-Centered Rating System, to which we added other elements derived from our own experience and understanding of person-centred-experiential therapies. At this point, GW joined the team and carried out a scoping exercise mapping the existing PCEPS items onto the newly drafted list of humanistic therapy competences (Roth, Hill & Pilling, 2009), and these competences onto the PCEPS. This led to the addition of items specific to experiential psychotherapies (e.g., emotion regulation). We then met regularly over the course of three months to pilot the instrument. During these meetings we listened to excerpts of audio-recordings of sessions from the Strathclyde Research Clinic archive and rated them using the instrument. After the ratings we discussed our scores, particularly when we found large discrepancies. These discussions led to further changes and amendments to the instrument, finally arriving at the current version (number 10.5) of the PCEPS. During this time we also experimented with different rating scales and attempted unsuccessfully to separate out adherence and competence, before agreeing to focus the instrument on competence, given that it assumes adherence already.

Instrument

The version of the PCEPS that we arrived at consists of 15 items (see Appendix 1) divided into two subscales: (a) Person Centred Process, and (b) Experiential Process. These two subscales replicate the division between nondirective (so-called "classical") person-centred therapy and its experiential off-shoots (eg, Focusing,

Emotion-Focused Therapy) and were devised as an attempt to measure and compare the practice of these therapies.

Each item of PCEPS has an introductory descriptive summary and a 6-point fully anchored rating scale. (See Table 2 for an example of one of these rating scales.) Anchors for scale points 4 to 6 were written to reflect varying degrees of competent performance, while scale points 1 to 3 reflect performance that we considered to fall below adequate levels of competence. The 10 items of the Person-Centred Process Subscale are 'Client Frame of Reference/Track', 'Core Meaning', 'Client Flow', 'Warmth', 'Clarity of Language', 'Content Directiveness', 'Accepting Presence', 'Genuineness', 'Psychological Holding', and 'Dominant or Overpowering Presence'. The 5 items of the Experiential Process Subscale are 'Collaboration', 'Experiential Specificity', 'Emotion Focus', 'Client Self-Development', and 'Emotion Regulation Sensitivity'.

Sample of audio-recorded segments

Sixty therapy sessions were selected from the archive of routinely audio-recorded therapy sessions in the Strathclyde Counselling and Psychotherapy Research Clinic. The sessions were systematically selected as follows: We identified 10 therapists each of whom had seen two clients who had given permission for their audio recordings to be used for research. Each client was represented by three sessions, selected from the first, middle, and last third of therapy. Two segments were selected from each session, representing the first and second half of the session. Furthermore, three of the therapists identified themselves as EFT (Emotion-Focused Therapy) practitioners and the other 7 therapists identified themselves as person-centred (PCT) practitioners. Six of the PCT therapists were experienced therapists; four of these were counsellors in training. Half of the segments were 10 min long and the other half were 15 min long. Only audio-recordings from clients and therapists who gave informed consent for this specific use of their therapy audio-recordings were selected. The research protocol was approved by the University of Strathclyde ethics committee.

Raters

The audio-recordings were rated independently by six raters, divided into two teams of three raters each. Of the six raters, three were qualified and experienced person-centred therapists and the other three raters were person-centred counselling trainees in their first year of training. The raters received a 12-hour training on the use of the PCEPS. After this initial training, the raters attended fortnightly two-hour monitoring meetings, where they received supervision and feedback on their ratings.

Procedures

Each rater rated 60 audio-recorded segments, one from each of the 60 sessions. The segments listened to by the two groups of raters were different. The raters were not informed which audio-recordings were from which type of therapy (i.e., person-centred or EFT), although they knew some of the therapists being rated, including two of the investigators.

Results

Reliability

Mean interrater reliabilities (Cronbach's alpha) for individual items varied from .68 to .86 (see Table 3). Average interrater reliability across the 15 items was .78, while the interrater reliability of the 15 items when averaged together was .87. Interitem reliability (alpha) for total scale (item scores averaged across raters) was .98

indicating a very high degree of internal consistency for the instrument and some degree of redundancy among items.

Exploratory Factor Analysis

Exploratory factor analysis (Gorsuch, 1983) is a quantitative method for using patterns of interitem correlation to identify underlying dimensions or implicit variables, similar to identifying implicit categories of meaning in a qualitative analysis. The 15 items of PCEPS were correlated with each other and the resulting intercorrelation matrix was subjected to the principal axis form of factor analysis. As part of this process, two measures of psychometric adequacy were used to see if the assumptions of factor analysis had been met. Both of these measures of psychometric adequacy indicated that the correlation matrix was suitable for factor analysis: Bartlett's test of sphericity indicated that the items were interdependent ($\chi^2 = 2923.1$, $p < 0.001$); the Kaiser-Meyer-Olkin measure of sampling adequacy was .96, well above the 0.5 minimally accepted level, indicating that the items belonged together psychometrically and contained enough variance that could be reliably factored.

We used the scree plot to help us determine how many factors to extract: This showed the very large proportion of the variance in the first component (77.6%) and suggested a clear break between the second and third factors, indicating that a two-factor solution was suitable for rotation (to increase its interpretability; Gorsuch, 1983). The two-factor solution accounted for 85.6% of the total variance. The factor loadings of the rotated factor matrix are displayed in Table 1. Factor 1 (with 12 items) accounted for 59.3% of the total variance and Factor 2 (with 3 items) accounted for 26.3% of the total variance.

The first factor (12 items) seemed to capture the common facilitative relationship conditions that cut across Person-Centred and Experiential subscales (alpha = .98). The second factor, which contained the items 'Dominant or Overpowering Presence', 'Content Directiveness', and 'Clarity of Language', seemed to be tapping into a process of apparently non-facilitative directiveness (alpha = .89).

Discussion

The good interrater reliability and internal consistency obtained in this field trial of the PCEPS are promising results. They indicate that the PCEPS is potentially a useful tool for use in clinical trials research on person-centred and experiential therapies, although it will require further testing and validation. For that purpose, the researchers are currently carrying out two other studies: an analysis of the convergent validity of the instrument, and a component of variance analysis (ie., Generalisability Study) in order to inform decisions about how best to sample psychotherapy/counselling sessions for adherence/competence evaluations. In addition to the use of PCEPS in clinical trials research, we consider that PCEPS could be an useful instrument in counselling training and supervision as a way of promoting best practice in person-centred and experiential therapies.

The reliability results also indicate that the instrument contains redundant items and could be shortened, which would make it easier for raters to use the instrument. We are developing a shorter, 10-item version that includes items from both theoretical scales and obtained factors. Strikingly, the factor structure of PCEPS found in this field trial did not replicate the theoretically driven distinctions between person-centred and experiential practices. Unexpectedly, all items in the 'Experiential Process' subscale were clustered together with other 'Person-Centred Process' items in the main factor (Factor 1). This surprising result needs further exploration and replication, using different samples of therapists and raters (e.g., equally qualified).

A limitation of this measure, common to other therapy process measures is that it generalizes from relative brief segments of therapy to therapist performance in general, while ignoring context and participant internal experiences. It could also be argued that the numbers and rating points of the scale are too limited to capture the qualities of the therapeutic relationship that are intangible, subtle, and perhaps even incommensurable. Critically, the therapeutic competence of the rater is likely to be crucial for the validity of the results. For instance, only a rater who is more empathic than the therapist would be able to assess adequately the therapist's level of empathy. Moreover, it is possible that a rater trained in the classical tradition of the person-centred approach would provide different ratings than a therapist trained in the experiential tradition.

Another limitation of this study is that the raters knew some of the therapists being rated, including two of the investigators, which undoubtedly influenced their ratings, in spite of efforts to counter bias. Moreover, because each rater rated the same therapist six times, it was likely that raters soon formed global impressions of therapists, which may have carried over to later ratings.

Conclusions

The PCEPS operationalises widely-held competences for humanistic psychotherapy and counselling (eg., Roth et al., 2009), and represents an extended effort to create a dialogue between nondirective person-centred and experiential "tribes" within the humanistic approaches. It was developed to support randomised clinical trials of person-centred and experiential psychotherapies but could also be used as an outcome measure in training studies. Although the present results need to be replicated, the PCEPS has many potential uses in professional training, ranging from initial counselling skill practice to professional accreditation and continuing professional development.

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References

Brodley, B. T., & Brody, A. (1990, August). *Understanding client-centered therapy through interviews conducted by Carl Rogers.* Paper presented at the annual conference of the American Psychological Association, Boston, MA.

Cronbach, L.J., Gleser, G.C., Nanda, H., & Najaratnam, N. (1972). *The dependability of behavioral measurements: Theory of generalizability for scores and profiles*. New York: Wiley.

Decker, S.E., Nich, C., Carroll, K.M., & Martino, S. (2013). Development of the Therapist Empathy Scale. *Behavioural and Cognitive Psychotherapy*. *Firstview article* retrieved online. doi:10.1017/S1352465813000039.

Freire, E., Elliott, R., & Westwell, G. (2011). *Person–centred & experiential psychotherapy scale (v. 10.5)*. Unpublished research instrument, Counselling Unit, University of Strathclyde, Glasgow, Scotland.

Gorsuch, R.L. (1983). *Factor analysis* (2nd ed.). Hillsdale, NJ: Lawrence Earlbaum Associates.

Lambert, M. J., Dejulio, S. S., & Stein, D. M. (1978). Therapist interpersonal skills: Process, outcome, methodological considerations and recommendations for future research. *Psychological Bulletin, 85,* 467-489.

Merry, T. (2004). Classical client-centered therapy. In Sanders, P. (Ed.), *The tribes of the person-centred nation: An introduction to the schools of therapy associated with the person-centred approach.* (pp. 21-44). Ross-on-Wye: PCCS Books.

Raskin, N. J. (2005). *The non-directive attitude.* In Levitt, B. E. (Ed.) *Embracing non-directivity: Reassessing person-centred theory and practice in the 21st century* (pp. 329-347). Ross-on-Wye: PCCS Books (original unpublished manuscript, 1947).

Roth, A.D., Hill, A., & Pilling, S. (2009). *The competences required to deliver effective Humanistic Psychological Therapies*. Centre for Outcomes Research and Effectiveness, University College London. Available online at: http://www.ucl.ac.uk/clinical-psychology/CORE/humanistic_framework.htm

Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counselling and psychotherapy: Training and practice.* Chicago: Aldine.

Waltz, J., Addis, M. E., Coerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy assessment of adherence and competence. *Journal of Consulting and Clinical Psychology, 61*, 620–630.

Ward, E., King, M., Lloyd, M., Bower, P., Sibbald, B., Farrelly, S., Gabbay, M., Tarrier, N., & Addington-Hall, J. (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I: Clinical effectiveness. *British Medical Journal, 321,* 1383-1388.

Watson, J.C., & Prosser, M. (2002). Development of an observer rated measure of therapist empathy. In J. C. Watson, R. Goldman, & M Warner (Eds.), *Client-centered and experiential psychotherapy in the 21st century: Advances in theory, research and practice* (pp. 303-314). Ross on Wye: PCCS Books.

Wilczynski, J., Brodley, B. T., & Brody, A. (2008). A rating system for studying nondirective client-centered interviews – Revised. *The Person-Centered Journal, 15,* 34-57.

Table 1.
Items of the Person-Centred and Experiential Psychotherapy Scale (PCEPS)

Part 1: PERSON-CENTRED PROCESS Subscale	
PC1. *Client frame of reference/track*	How much do the therapist's responses convey an understanding of the client's experiences as the client themselves understands or perceives it? To what extent is the therapist following the client's track?
PC2. *Core meaning*	How well do the therapist's responses reflect the core, or essence, of what the client is communicating or experiencing in the moment?
PC3. *Client flow*	In terms of the pacing of the client's process, how well is the therapist responsively attuned to the client's flow moment by moment in the session?
PC4. *Warmth*	How well does the therapist's tone of voice convey appropriate warmth?
PC5. *Clarity of language*	How well does the therapist use language that communicates simply and clearly to the client?
PC6. *Content directiveness*	How much do the therapist's responses intend to direct the client's content?
PC7. *Accepting presence*	How well does the therapist's attitude convey an unconditional acceptance of whatever the client brings?
PC8. *Genuineness*	How much does the therapist respond in a way that genuinely and naturally conveys their moment to moment experiencing of the client?
PC9. *Psychological holding*	How well does the therapist metaphorically hold the client when they are experiencing painful, scary, or overwhelming experiences, or when they are connecting with their vulnerabilities?
PC10. *Dominant or overpowering presence*	To what extent does the therapist project a sense of dominance or authority in the session with the client?
Part 2: EXPERIENTIAL PROCESS Subscale	
E1. *Collaboration*	How much does the therapist appropriately and skilfully work to facilitate client-therapist collaboration and mutual involvement in the goals and tasks of therapy?

E2. *Experiential Specificity*	How much does the therapist appropriately and skilfully work to help the client focus on, elaborate or differentiate specific, idiosyncratic or personal experiences or memories, as opposed to abstractions or generalities?
E3. *Emotion Focus*	How much does the therapist actively work to help the client focus on and actively articulate their emotional experiences and meanings, both explicit and implicit?
E4. *Client Self-development*	How much does the therapist actively work to facilitate client new awareness, growth, self-determination or empowerment?
E5. *Emotion Regulation Sensitivity*	How much does the therapist actively work to help the client adjust and maintain their level of emotional arousal for productive self-exploration?

Table 2.
Example of PCEPS Item Wording and Anchored Rating Scale

PC1. CLIENT FRAME OF REFERENCE/TRACK:

How much do the therapist's responses convey an understanding of the client's experiences as the client themselves understands or perceives it? To what extent is the therapist following the client's track?

Do the therapist's responses convey an understanding of the client's inner experience or point of view immediately expressed by the client? Or conversely, do therapist's responses add meaning based on the therapist's own frame of reference?
Are the therapist's responses right on client's track? Conversely, are the therapist's responses a diversion from the client's own train of thoughts/feelings?

1	**No tracking**: Therapist's responses convey no understanding of the client's frame of reference; or therapist adds meaning based completely on their own frame of reference.
2	**Minimal tracking**: Therapist's responses convey a poor understanding of the client's frame of reference; or therapist adds meaning partially based on their own frame of reference rather than the client's.
3	**Slightly tracking**: Therapist's responses come close but don't quite reach an adequate understanding of the client's frame of reference; therapist's responses are slight "off" of the client's frame or reference.
4	**Adequate tracking**: Therapist's responses convey an adequate understanding of the client's frame of reference.
5	**Good tracking**: Therapist's responses convey a good understanding of the client's frame of reference.
6	**Excellent tracking**: Therapists' responses convey an accurate understanding of the client's frame of reference and therapist adds no meaning from their own frame of reference.