

This is the peer reviewed version of the following article: Ryan, G., Bhatti, K., Duncan, C., McGinnis, S., Elliott, R., & Cooper, M. (2021). Reliability and validity of an auditing tool for person-centred psychotherapy and counselling for young people: The PCEPS-YP. Counselling & Psychotherapy Research, Advance online publication. It has been published in final form at DOI: 10.1002/capr.12505. This article may be used for non-commercial purposes in accordance with Wiley Terms and Conditions for Use of Self-Archived Versions. This article may not be enhanced, enriched or otherwise transformed into a derivative work, without express permission from Wiley or by statutory rights under applicable legislation. Copyright notices must not be removed, obscured or modified. The article must be linked to Wiley's version of record on Wiley Online Library and any embedding, framing or otherwise making available the article or pages thereof by third parties from platforms, services and websites other than Wiley Online Library must be prohibited.

Reliability and Validity of an Auditing Tool for Person-Centred Psychotherapy and Counselling for Young People: The PCEPS-YP

Gemma Ryan¹

British Association for Counselling and Psychotherapy

Kiran Bhatti

University of Roehampton

Charlie Duncan

British Association for Counselling and Psychotherapy

Susan McGinnis

University of Strathclyde

Robert Elliott

University of Strathclyde

Mick Cooper

University of Roehampton

Word count: 6341

Keywords: counselling, psychotherapy, person-centred, measure, validation

ABSTRACT

The present study aimed to test the reliability and validity of the Person Centred and Experiential Psychotherapy Scale–Young Person version (PCEPS-YP). This is a newly developed and adapted 9-item scale which aims to measure counsellor competences in, and adherence to, person-centred practise, when working with adolescents. Counselling practice was assessed for 19 counsellors by randomly selecting 20-minute audio segments from 142 recorded counselling sessions. Audio material was independently rated by eight raters using the PCEPS-YP to produce an average adherence rating per counsellor. Scale reliability was assessed via interrater reliability and internal consistency

¹ Corresponding author: Gemma Ryan; gemma.ryan@city.ac.uk; 07340109163; Social Sciences Building, City University of London, Northampton Square, London, EC1V 0HB

testing. Convergent validity was tested using ratings from the observer-rated Barrett-Leonard Relationship Inventory (BLRI Obs 40) and the scale was subjected to exploratory factor analysis. Results showed a high degree of internal consistency within raters ($\alpha = .95$), marginally acceptable reliability across grouped raters ($\alpha = .58$), and weaker reliability between pairs of raters ($\alpha = .50$). Exploratory factor analysis revealed one strong factor for the scale with no subscales. Small to moderate correlations existed between the PCEPS-YP and the BLRI subscales and mean total score ($r_s = .12$ to $.40$). Our findings suggest that the PCEPS-YP has potential as an effective, reliable, and valid tool for assessing competence and adherence in person-centred practice with young people, both for research and clinical purposes. However, training procedures need to be established that can enhance interrater reliability, and more evidence of convergent validity is needed.

Reliability and Validity of an Auditing Tool for Person-Centred Psychotherapy and Counselling for Young People: The PCEPS-YP

Intervention integrity is a vital component in clinical research trials. An inadequate intervention can reduce effectiveness and compromise the validity and reliability of trial results (Vitolins et al., 2000). Past research has been criticised for failing to rigorously check independent variables in behavioural trials, which can cause researchers to mislabel a causal relationship between variables (Cook et al., 1979). To avoid this, Peterson et al. (1982) recommend that researchers monitor both the dependent and independent variables to improve intervention integrity and trial accuracy. In addition, monitoring the delivery of a trial intervention provides an opportunity to identify and correct non-adherent practice.

There are two major approaches to evaluating intervention integrity in psychotherapy (Webb et al., 2010): *adherence* is the extent to which therapeutic techniques match the theory-derived treatment model; *competence* refers to the therapist's skill in implementing those techniques. Within psychotherapy, adherence measures mostly focus on cognitive behavioural interventions, such as the Cognitive-Behavioral Therapy Adherence Scale for Youth Anxiety (Southam-Gerow et al., 2016). A similar situation holds for competence, with the most widely used measure being the Cognitive Therapy Scale Revised (Blackburn et al., 2001).

Humanistic therapies are a family of counselling and psychotherapy approaches that aim to facilitate the actualisation of the client's potential and their authentic being in the world (Cain et al., 2016). Person-centred therapy, one of its predominant forms, places particular emphasis on the provision of an empathic, non-judgmental, and relatively non-directive therapeutic relationship (Rogers, 1951, 1957, 1959). Despite being one of the most common forms of counselling and psychotherapy in the UK and worldwide (Elliott et al., 2021), there are very few measures that assess either adherence or competence to humanistic and/or person-centred practice. The principal exception to this is the Barrett-Lennard Relationship Inventory (BLRI, Barrett-Lennard, 2015), which can be used to assess the therapist interpersonal skills of empathy,

congruence, unconditionality, and level of regard from an observer perspective (though the tool is more commonly used for therapist- or client-self-report). The Truax Accurate Empathy Scale (Truax, 1967) has also been used as a measure of therapist competence in person-centred therapy (e.g., Goldman et al., 2006), as has Watson and Prosser's (2002) Measure of Expressed Empathy (MEE). However, Freire et al. (2014) have argued that these instruments' abilities to measure all components of person-centred therapy are limited.

More recently, the *Person-Centred and Experiential Psychotherapy Scale* (PCEPS) was developed by Freire et al. (2014) to address this problem. The PCEPS was developed on the basis of a set of evidence-based humanistic competences (Roth et al., 2009). It consisted of 15 items, designed to assess both classical person-centred practice (e.g., empathy, non-directiveness) and elements of more contemporary experiential practice (e.g., emotion-focus, specificity). Each item contained a descriptive summary and a descriptively anchored 6-point scale ranging from 1 = *non-adherence* to 6 = *expert-level competence*. The developers attempted to separate adherence from competence but eventually settled on a hybrid approach, with the lower rating scores representing non-adherence while higher rating scores indicated increasing levels of competence. Freire et al. (2014) found this to be a reliable measure of adherence/ competence for person-centred and experiential psychotherapies, reporting the PCEPS to have an overall interrater reliability (Cronbach's α) of .87, and an internal reliability (α) of .98. However, tests of convergent validity against the Working Alliance Inventory–Short Form (revised) and other relationship measures gave inconclusive results (Freire et al., 2014; Westwell et al., 2012).

Tools to assess treatment integrity in humanistic and person-centred therapy with children and young people are even less well-established. To address this problem, the PCEPS was adapted by McGinnis and Elliott (2016) for therapeutic work with young people. To do this, they used the competences framework for working with 11–18-year-olds (British Association for Counselling & Psychotherapy [BACP], 2017). This resulted in a new instrument: *The Person-Centred Experiential Psychotherapy Scale – Young Person Version* (PCEPS-YP). However, neither reliability nor validity have been determined for this measure. Hence, the current paper aims to assess the psychometric properties of the PCEPS-YP. Specifically, we aimed to investigate the following:

1. What is the internal consistency (α) of the PCEPS-YP and to what extent do scale items correlate with each other? We predicted good internal consistency of $\alpha \geq .70$ and $r \geq .70$.
2. What is the interrater reliability (α) of the PCEPS-YP (item and mean scores) for a) mean ratings for each counsellor, taken across all raters, and b) pairs of raters rating 20-minute audio segments of sessions? Values of alpha $\geq .70$ were predicted and an alpha value of $\geq .60$ was taken an acceptable level.
3. How many factors are present in the PCEPS-YP scale? All items of the PCEPS-YP were predicted to load onto one factor with no subscales.
4. To what extent does the PCEPS-YP correlate with the observer-rated BLRI? We aimed to detect a statistically significant and medium to

large correlation ($.8 \geq r \geq .5$) between the mean PCEPS-YP score and BLRI subscales.

Methods

Design

The PCEPS-YP was used to measure counsellor adherence as part of the Effectiveness and Cost-effectiveness Trial of Humanistic Counselling in Schools (ETHOS, Cooper et al., 2021; Stafford et al., 2018). ETHOS was a randomised controlled trial that assessed the effectiveness of school-based humanistic counselling (SBHC) versus pastoral care as usual (PCAU) with a total of 329 pupils across 18 secondary schools in London, UK. The SBHC intervention was delivered in a maximum of 10 sessions, by 19 counsellors. Counsellors were assigned a caseload of between 2 and 15 pupils, seeing an average of 9 pupils.

Participants

Clients

In total, 329 student participants across 18 London secondary schools were recruited into the ETHOS trial through school pastoral care teams and were allocated to either the intervention arm (school based humanistic counselling) or treatment as usual (pastoral care as usual) using a 1:1 ratio. Eligible participants for the trial were 13-16 years and had been identified as experiencing moderate to severe levels of emotional distress, using the Emotional Symptoms subscale of the Strengths and Difficulties Questionnaire. Exclusion criteria ruled out students who were currently receiving another therapeutic intervention, or those considered at risk of serious harm to self or others.

Of the 167 pupils who were allocated to the intervention arm, PCEPS-YP ratings were completed for 73 randomly selected pupils. Random selection was through an online Random Integer Set Generator from each counsellor's caseload (maximum of 4, and minimum of 2, clients per counsellor). From each caseload, four intakes (e.g., one intake of clients per academic term) were randomly selected for each counsellor, so that data were spread across the counsellor's period of involvement in the trial.

Counsellors

Nineteen counsellors were recruited to the ETHOS trial via an online advert placed on the BACP website, the University of Roehampton Website, and in BACP's magazine *Therapy Today*. Counsellors were mostly female (84%) with a mean age of 45.0 years (SD=9.0). Almost three quarters (73.6%) of counsellors were white British and others were of a black Caribbean or African ethnicity. All had a minimum of a two-year diploma level qualification and had been qualified for an average of 7.2 years (SD=6.6). Counsellors were instructed to practise a manualised form of SBHC, developed for the trial (Kirkbride, 2016). In terms of principal therapeutic orientation, 11 of the counsellors identified as 'person-centred', six as 'integrative', and two as 'humanistic'.

Raters

Individuals with person-centred counsellor training and experience were recruited via a university temping agency and paid to complete part-time,

temporary work that involved listening to counselling sessions and rating therapist intervention adherence using the PCEPS-YP. Nine prospective raters attended one full day of training, which concluded with listening to—and rating—eight session recordings that had previously been rated by experts in the person-centred field. Eight raters, who rated recorded counselling sessions within one point (i.e. < 1.0 point divergence) of these ‘calibration’ ratings on mean scores, and who demonstrated a minimum correlation of 0.9 between ratings across segments, were then recruited as paid raters. Three raters were male and five were female, with six qualified counsellors and two trainees. The majority of raters had a person-centred theoretical orientation.

One rater was also used for the convergent validity assessment and had extensive experience using the BLRI Obs 40. This rater (second author) is female and had training and experience in counselling psychology.

Measures

Person Centred and Experiential Psychotherapy Scale – Young Person Version (PCEPS-YP)

The PCEPS-YP is a 9-item therapy integrity tool. It was adapted from the original 15-item adult PCEPS to rate adherence/competence to person-centred practice with young people, as expressed in a manual for SBHC (Kirkbride, 2017). The measure was developed by the fourth author, a person-centred counsellor and trainer with extensive experience delivering counselling with a young population; and the fifth author, a humanistic and emotion-focused therapist and one of the developers of the original PCEPS. The measure was developed through drawing on the BACP (2017) framework for humanistic competencies with young people, the 15-item version of the original PCEPS, and the fourth author’s experiences of working as a counsellor with young people. This iterative process involved the two developers reviewed and refining the wording for items and rating scale anchors. Once final items were agreed upon, both scale authors tested the scale by rating audio recordings of young people’s counselling sessions and comparing ratings for further refinement.

This process resulted in the following nine PCEPS-YP items: ‘Client Frame of Reference’, ‘Tracking’, ‘Empathic Resonance’, ‘Accepting Presence’, ‘Genuineness’, ‘Emotion Focus’, ‘Emotion Symbolisation’, ‘Facilitation of Client Self-Development’, and ‘Developmental Responsiveness’. A short description was developed for each item alongside example questions that the rater may ask to aid their rating. For instance, for Item 4 (Accepting Presence), the rater is invited to consider, ‘To what degree is the therapist able to hold a consistent welcoming and non-judgmental attitude?’ Each item of the measure is rated on a scale of 1 (‘complete nonadherence’) to 6 (‘expert-level competence’). For accepting presence, then, a score of 1 is described as indicating ‘*explicit nonacceptance*’, which a score of 6 is described as indicating ‘*excellent acceptance*’. Across the nine items, an average overall score (“mean PCEPS-YP score”) is then computed ranging from 1 (non-adherence) to 6 (expert-level competence). Based on cut points for the PCEPS, a mean score of 3.5 or less was deemed to demonstrate unacceptable levels of adherence/competence.

Barrett-Lennard Relationship Inventory ([BLRI] Obs 40-Version 3)

The BLRI Obs 40, developed by Barrett-Lennard (1959; 1962), is an observer-rated scale consisting of 40 items. This is a shortened version,

adapted from the original 64-item scale. The instrument aims to measure therapist interpersonal skills and is based on the 'core conditions' of person-centred therapy (Rogers, 1957). The instrument has four subscales with 10 items each: 'Empathic Understanding', 'Level of Regard', 'Unconditionality of Regard', and 'Congruence'. Observers rate the extent that therapists demonstrate these conditions using a 6-point agreement–disagreement scale to indicate the extent to which they feel the statements are true, ranging from -3 (*No, I feel strongly that is not true*) to +3 (*Yes, I feel strongly that is true*).

Support for the BLRI Obs 40's reliability and validity comes primarily from the evaluation of the original 64-item self-report scale with adults (Barrett-Lennard, 1962). The internal consistency of the subscales from the original developmental study was assessed using the split-half method and found to be highly correlated ($r \geq 0.82$ for each sub-scale), suggesting satisfactory internal consistency (Barrett-Lennard, 1962). Subsequent evaluation of the BLRI was carried out by Gurman (1977) and demonstrated good internal consistency across 14 studies ($r = .91$ for total BLRI score). Support for test–retest reliability over a period of 4 weeks has also been established ($r = .95$, Barrett-Lennard, 1962). A review of three factor analysis studies suggested good construct validity (Gurman, 1977) supporting the four-subscale dimensionality of the BLRI.

Specific psychometric evidence for the 40-item observer rater BLRI is in its infancy, and particularly with children and young people. However, internal consistency across the 40 items of the BLRI was found to be very high in ratings of young people ($\alpha = .93$), and the measure was supported in confirmatory factor analysis (CFA) (Bhatti et al., 2021).

Procedure

The eight independent raters used the PCEPS-YP to measure therapeutic adherence for all 19 counsellors by rating an average of four pupils (minimum of two pupils) per counsellor, two counselling sessions per pupil. The two recorded sessions were randomly selected from across the course of the pupil's counselling, selecting sessions from the first and last halves of their treatment, excluding the first and last counselling sessions. If only one counselling session was available for a pupil, then two randomly selected non-overlapping segments were taken from the session and used for rating. All sessions were recorded with both the counsellor's and pupil's permission, as per the ethics procedure approved by the University of Roehampton Ethics Board.

From the selected session recordings, 20-minute audio segments (or shorter, depending on the original recording length, with a minimum segment length of 10 minutes) were randomly selected and cut using Audacity software. The audio segment was selected by excluding the first and final 5 minutes of the recording and randomly generating a start timepoint between 'minute 5' and 'recording length minus 25-minutes.' For example, if the session was 50 minutes in length, the start time was randomly generated between minutes 5 and 25. If the recording length was under 30 minutes but over 20-minutes, the final 20-minutes of the recording were used. If recording length was under 20-minutes but over 10-minutes, then the whole recording was used. If recording length was under 10-minutes the session was discarded and another randomly

selected (see Stafford et al., 2018 for further detail). All randomisation was conducted using an online Random Integer Set Generator.

In total, 142 segments were each rated by two raters. The raters were randomly assigned segments across all sessions and counsellors, with every rater rating every counsellor at least twice. Each segment was rated by a pair of raters, with all rater pairs randomly assigned so that every rater rated against each other rater throughout the process.

To minimise 'drift' in raters' assessments across the duration of the project, halfway into the rating process we randomly inserted eight 'calibration segments' into the raters' batches that had been assessed by national experts. To maintain rating standards, raters were required to show at least 90% matching with the expert rating for each individual scale item and the mean PCEPS-YP score. Where this did not occur, an expert rater discussed results with the rater to provide additional training.

For the purposes of assessment of counsellor adherence in our trial [reference masked for anonymity], we used adjusted ratings (with an independent expert rater) where raters' mean segment ratings differed by more than 1.0 point per recording (103 out of 142 recordings, 72.5%). However, for the present psychometric analyses, we use the raters' unadjusted ratings only, either individually or combined.

To assess convergent validity, a selection of 50 segments was chosen from the 142. Segments were selected at random and rated using both the PCEPS-YP and the BLRI Obs 40 by one rater. The rater listened to each extract once and rated the audio using both the PCEPS-YP and BLRI.

Analysis

All analyses were conducted using SPSS (see Table 4 for a summary of all analyses performed). Frequencies were tallied for individual PCEPS-YP mean ratings to assess the percentage of segments where counsellors met the agreed 3.5 cut-off for acceptable adherence. Reliability and validity analyses of the PCEPS-YP were performed using raters' individual ratings. Internal consistency was analysed using all ratings from the raters to obtain Cronbach's alpha for the scale. Inter-item correlations and corrected item-totals were checked respectively for poor correlation ($r < .3$) or redundancy ($r > .8$) of scale items.

Interrater reliability was assessed using reliability analyses for the PCEPS-YP scale items and mean score for i) *grouped ratings* and ii) *paired ratings*. *Grouped ratings* were the mean ratings for each counsellor (encompassing different sessions and clients), taken across all raters for each PCEPS-YP item and mean score. *Grouped ratings* were used to obtain a more accurate and representative counsellor adherence score by observing practice across sessions and clients. *Paired ratings* were the segment-level ratings for the PCEPS-YP (scale items and mean score) provided by pairs of two raters independently.

Construct validity was tested using exploratory factor analysis (EFA) on PCEPS-YP items for all 284 segment ratings by individual raters. A varimax orthogonal rotation was used with principal axis factoring. The scree plot was assessed in conjunction with produced eigenvalues to determine the number of

factors. All eigenvalues > 1.0 were retained, in line with Kaiser's (1960) recommendation.

Convergent validity was assessed using the BLRI-Obs 40 and PCEPS-YP ratings of 50 segments by a single rater. An estimate of the expected correspondence between PCEPS-YP total (averaged across the two raters) and BLRI total were tested using Pearson's Product Moment Correlation.

Results

Descriptive Analyses

Individual PCEPS-YP mean ratings ranged between 1.7 and 6.0, with a mean of 4.6 out of 6 (see Table 1). Overall, 90.1% of ratings were equal to, or surpassed, the 3.5 agreed cut-off for acceptable adherence.

Internal Consistency

Analysis indicated an inter-item reliability of $\alpha = .95$ for individual PCEPS-YP segment ratings ($n = 284$). All scale items had strong corrected-item total correlations ($r > .7$ for all items). Correlations between unadjusted item scores ranged from $r = .52$ for items 6 and 4 (emotion focus and acceptance) to $r = .85$ for items 7 and 6 (emotion focus and emotion symbolisation; see Table 3).

Interrater Reliability

Interrater reliability for the PCEPS-YP mean score ($n = 284$), at the paired level, was $\alpha = .50$. This is equivalent to ICC (2,2) for consistency among multiple raters, McGraw & Wong, 1996. For ratings of scale items, the interrater reliability varied from .30 (developmental responsiveness) to .50 (empathic resonance; see Table 2).

For grouped ratings, the interrater reliability of mean PCEPS-YP scores was: .58 (Cronbach's alpha for the 8 raters; equivalent to ICC (2,8)). For grouped ratings, the reliability of scale items ranged from .18 (tracking) to .58 (empathic resonance).

Unidimensionality

The Kaiser-Meyer-Olkin measure of sampling adequacy was 0.93, well above the commonly recommended value of 0.6, and Bartlett's test of Sphericity was significant ($X^2(36) = 2239.9$, $p < 0.001$). Communalities were above 0.3 for all PCEPS-YP items, which further confirmed that each item shared some common variance. These tests indicated that the scale items met assumptions for factor analysis and contained enough variance to be reliably factored.

Results of the factor analysis produced a scree plot and eigenvalues that suggested one clear factor in the scale. Factor 1 had an eigenvalue of 6.3 that explained 70.4% of the variance. Each of the remaining factors contained an eigenvalue less than 1.0. This suggests one clear and strong factor and indicates no subscales in the PCEPS-YP.

Convergent Validity

The BLRI subscales of congruence and empathy significantly correlated with the PCEPS-YP mean score averaged across raters (congruence, $r = .33$, $p = .02$; empathy, $r = .40$, $p < 0.01$). However, the correlation between the unconditionality and regard subscales and the mean PCEPS-YP score was non-significant (regard, $r = .19$, $p = .19$; unconditionality, $r = .12$, $p = .40$). The correlation between the PCEPS-YP and the total BLRI score was $r = .37$, $p < .01$.

Discussion

The PCEPS-YP was specifically adapted for use within an RCT to measure treatment integrity in counsellors working with a young population. Previously, conclusions from the PCEPS-YP regarding intervention integrity were limited due to an absence of reliability testing, however results from the present study suggest this measure has promising levels of reliability, especially when averaged at the counsellor level across multiple sessions to reduce error variance.

Inter-item reliability tests revealed a very high Cronbach's α for the PCEPS-YP, which indicates excellent consistency among items measuring the same construct. Indeed, this is high enough to indicate some item redundancy. Corrected item–total correlations suggested that all items strongly correlated with the scale total. Very high correlations between emotion focus and emotion symbolisation, as well as among the three empathy items (emotion focus, emotion symbolisation, and empathic resonance), points to the potential to shorten the scale to six or fewer items. This could also indicate the value of additional training to raters to differentiate more clearly between these items.

Our analysis indicates marginally acceptable reliability across grouped ratings of individual counsellors. Furthermore, for paired ratings, the interrater reliability for the mean total scale is 'poor' and for individual scale items 'unacceptable' (George & Mallery, 2003). This suggests that raters did not use the PCEPS-YP in consistent ways. This could be due to a number of reasons. The competence level of some raters may have been insufficient for the skills required to use this instrument; for example, some of the recruited raters were student counsellors. Another factor could be due to the 20-minute length of audio material that may provide too much information for raters to integrate consistently. In contrast to the present study, Freire et al. (2014) required raters to rate 10-15 minutes of audio material for the original PCEPS validation, and obtained a three-rater total scale interrater reliability of $\alpha = .86$, equivalent to a mean interrater r of .67. Most importantly, perhaps, Freire et al. trained raters for 10-12 weeks before they conducted formal ratings on the segments. This compares markedly with the single day's training that raters in the present study participated in.

Based on this analysis, it seems likely that lengthier training and shorter audio segments might improve the reliability of ratings. Further methods for enhancing interrater reliability may include trainers providing feedback on problem items from the PCEPS-YP, achieving unforced consensus through open dialogue, building rater camaraderie, and regularly checking for rater drift throughout the rating process. In a study that evaluated reliability of a newly developed PCEPS-10, Westwell and Elliott (2018) developed and implemented a set of training procedures that successfully improved interrater reliability from $\alpha = 0.73$ to $\alpha = 0.82$. As above, these procedures included reducing the rated segment length to 10 minutes (from 20-30 minutes previously), implementing a rater notation system, and self-reporting of emotional reaction towards therapists to check for emotion-bias. Furthermore, analysis of raters' experiences revealed these changes were seen as a helpful aid to the rating process.

Low interrater reliability may also suggest that multiple ratings are needed to achieve a standard α reliability level of .7: for example, ratings from at least three—and preferably four—raters. In future, therefore, it is proposed that PCEPS-YP rating should involve groups of three raters, or at minimum—as with the present study—there should be a third independent rater.

Convergent validity for the PCEPS-YP was within acceptable ranges against the BLRI Obs 40 total score, as well as empathy and congruence subscale scores. This suggests that the measure is ‘tapping’ core person-centred therapist interpersonal skills. However, correlations with regard and unconditionality fell below the expected range. This suggests that the PCEPS-YP may need some modification to cover the full range of person-centred therapist interpersonal skills. For instance, consideration should be given to adding a tenth, ‘warmth’ item that may tap the affiliative, caring, and relationally deep stance that person-centred therapists are expected to adopt—above and beyond acceptance (Item 4) *per se*. Further testing of convergent validity is also required against non-person-centred measures, such as the Working Alliance Inventory (Hatcher and Gillaspay, 2006); with investigation of divergent validity also required.

As predicted, factor analysis revealed one clear and strong factor of the PCEPS-YP, indicating no subscales. Further validity tests demonstrated a moderate relationship between the BLRI and the PCEPS-YP, which suggests promising results for the PCEPS-YP as a measure of therapeutic adherence and strengthens conclusions from the ETHOS trial regarding intervention integrity. However, the high correlation between the PCEPS-YP and BLRI Obs 40 could suggest the scales are redundant with each other and, indeed, the first five items of the PCEPS-YP constitute a ‘mini-BLRI’. However, the PCEPS-YP provides a broader assessment of PCE counselling skills, including some not covered by the BLRI (e.g., Developmental Responsiveness). In addition, the PCEPS-YP items are more thoroughly described and anchored using more precise, technical language. The BLRI, on the other hand, has the advantages that it is written in lay language and focuses entirely on relational variables, thus allowing parallel client and therapist versions. It also allows for separate evaluation of four therapist interpersonal skills.

Future research should evaluate the reliability and validity of the PCEPS-YP in measuring therapeutic adherence for a broader age range of the child and young person population. The PCEPS-YP was developed based on an original set of competences that covered therapeutic work with children aged 11-18 years (BACP, 2017). However, BACP recently updated this framework to include children aged 4-18 years (BACP, 2019). It would therefore be valuable to repeat reliability and validity tests of the PCEPS-YP using therapeutic sessions with younger children to assess whether the scale can be reliably used in research trials with this population.

It would also be useful to run components of variance analyses to assess variability due to raters, clients, therapists, and sessions. This would help make decisions about segment selection in future. For example, Westwell et al. (2011) reported that sampling early or late in sessions or in therapy made little or no difference in PCEPS ratings; instead, they found that most of the variance was accounted for by therapists and clients within therapists.

The PCEPS-YP could also be used to identify sessions characterised by very low or very high levels of therapist adherence/competence, so that these could be studied further or used for future rater training.

Limitations

A principal limitation of this study was that our test for convergent validity was dependent on just one rater. For future analysis, it will be essential to have multiple, independent raters comparing the PCEPS-YP against other measures, including the BLRI Obs 40. Another important limitation of this study, in terms of developing evidence for the reliability and validity of the PCEPS-YP, is that we may have provided insufficient training for our raters. This likely explains why interrater reliability was low. Hence, we cannot be certain how the PCEPS-YP would perform under optimal conditions. In addition, as raters rated therapists more than once, ratings were not independent. This means that biases may have formed in their ratings. In addition, all analyses would, ideally, use complex multilevel procedures to account for within-therapist groupings.

Implications for Practice

Although the PCEPS-YP was developed primarily for evaluating treatment integrity in studies of person-centred counselling with young people, once its reliability and validity have been established, it has a potentially wide range of clinical applications. This includes use in supervision, training, and accreditation of therapists, as has been done with the PCEPS-10. For example, a psychometrically robust PCEPS-YP could be used for providing feedback on therapist interpersonal skills on training courses for person-centred work with young people. It could also be used to evaluate readiness to practice and qualification decisions. A counsellor self-report version could also be created as a self-monitoring tool for therapists in training or practice.

Conclusion

The PCEPS-YP was developed to address the need for an instrument that could measure therapist interpersonal skills for person-centred and humanistic counselling with a young population. Preliminary analyses indicate this measure may be an effective, reliable, and valid tool for assessing therapeutic competence and adherence for young people aged 11-18 years old. Though further testing and training protocols are required, the PCEPS-YP holds potential for both research and practice developments in the person-centred field.

References

- Barrett-Lennard, G. T. (2015). *The relationship inventory: A complete resource and guide*. John Wiley & Sons.
- Barrett-Lennard, G. T. (1959). *Dimensions of perceived therapist response related to therapeutic change* [Doctoral dissertation, University of Chicago, Department of Psychology].
- Barrett-Lennard, G. T. (1962). Dimensions of therapist response as causal factors in therapeutic change. *Psychological monographs: General and applied*, 76(43), 1.

- Bhatti, K., Pauli, R., & Cooper, M. (2021). Psychometric Evaluation of the Barrett-Lennard Relationship Inventory Observer Form (BLRI Obs-40) for Young People. *Manuscript in Preparation*.
- Blackburn, I. M., James, I. A., Milne, D. L., Baker, C., Standart, S., Garland, A., & Reichelt, F. K. (2001). The revised cognitive therapy scale (CTS-R): psychometric properties. *Behavioural and cognitive psychotherapy*, 29(4), 431.
- British Association for Counselling and Psychotherapy. (2017). *Competences for work with young people (11–18 years)*. BACP. <https://www.bacp.co.uk/media/2335/bacp-competences-map-for-working-with-young-people.pdf>
- British Association for Counselling and Psychotherapy (2019). *Competences and curricula: Children and young people*. BACP. <https://www.bacp.co.uk/events-and-resources/ethics-and-standards/competences-and-curricula/>
- Cook, T. D., & Campbell, D. T. (1979). *Quasi-Experimentation: Design and Analysis Issues for Field Settings*. Houghton Mifflin.
- Cooper, M., Stafford, M. R., Saxon, D., Beecham, J., Bonin, E. M., Barkham, M., Bower, P., Cromarty, K., Duncan, C., Pearce, P., Rameswari, T., & Ryan, G. (2021). Humanistic counselling plus pastoral care as usual versus pastoral care as usual for the treatment of psychological distress in adolescents in UK state schools (ETHOS): a randomised controlled trial. *The Lancet Child & Adolescent Health*, 5(3), 178-189.
- Elliott, R., Watson, J. C., Timulak, L., & Sharbanee, J. (2021). Research on humanistic-experiential psychotherapies: Updated review. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (7th ed.). New Jersey: John Wiley.
- Folke, S., Daniel, S., Gondan, M., Lunn, S., Tækker, L., & Poulsen, S. (2017). Therapist adherence is associated with outcome in cognitive-behavioral therapy for bulimia nervosa. *Psychotherapy*, 54(2), 195-200. <https://doi.org/10.1037/pst0000107>
- Freire, E., Elliott, R., & Westwell, G. (2014). Person-Centred and Experiential Psychotherapy Scale: Development and reliability of an adherence/competence measure for person-centred and experiential psychotherapies. *Counselling And Psychotherapy Research*, 14(3), 220-226. <https://doi.org/10.1080/14733145.2013.808682>
- George, D., & Mallery, P. (2003). *SPSS for Windows step by step: A simple guide and reference*. 11.0 update (4th ed.). Boston: Allyn & Bacon
- Goldman, R. N., Greenberg, L. S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research*, 16(5), 536–546. <https://doi.org/10.1080/10503300600589456>
- Gurman, A. S. (1977). Therapist and patient factors influencing the patient's perception of facilitative therapeutic conditions. *Psychiatry*, 40(3), 218-231.
- Hatcher, R. L., & Gillaspay, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, 16(1), 12-25. <https://doi.org/10.1080/10503300500352500>

- Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and psychological measurement*, 20(1), 141-151.
- Kirkbride, R. (2017). *Counselling young people: A Practitioner Manual*. SAGE Publications Ltd.
- Peterson, L. Homer, A. & Wonderlich, S. (1982) The integrity of independent variables in behavior analysis. *Journal of applied behavior analysis*, 15(4), 477–492. <https://doi.org/10.1901/jaba.1982.15-477>
- Rogers, C. R. (1951). *Client-Centered Therapy*. Boston: Houghton and Mifflin.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95-103.
- Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A Study of Science* (Vol. 3, pp. 184-256). New York: McGraw-Hill.
- 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. http://www.ucl.ac.uk/clinical-psychology/CORE/humanistic_framework.htm
- Schoenwald, S., & Garland, A. (2013). A review of treatment adherence measurement methods. *Psychological Assessment*, 25(1), 146-156. <https://doi.org/10.1037/a0029715>
- Southam-Gerow, M., McLeod, B., Arnold, C., Rodríguez, A., Cox, J., & Reise, S. et al. (2016). Initial development of a treatment adherence measure for cognitive-behavioral therapy for child anxiety. *Psychological Assessment*, 28(1), 70-80. <https://doi.org/10.1037/pas0000141>
- Stafford, M., Cooper, M., Barkham, M., Beecham, J., Bower, P., & Cromarty, K. et al. (2018). Effectiveness and cost-effectiveness of humanistic counselling in schools for young people with emotional distress (ETHOS): study protocol for a randomised controlled trial. *Trials*, 19(1). <https://doi.org/10.1186/s13063-018-2538-2>
- The Cochrane Collaboration. (2019, September 20). *7.3.4 Interventions*. https://handbook-5-1.cochrane.org/chapter_7/7_3_4_interventions.htm.
- Westwell, G., & Elliott, R. (2018, July 8-12). *Articulating Person Centred Experiential practice: The development of the PCEPS-10 (a competence/adherence measure for PCE therapy)* [Conference presentation]. 13th World Conference on Person-Centred and Experiential Psychotherapy and Counselling 2018, Vienna, Austria.
- Truax, C. B. (1967). The training of nonprofessional personnel in therapeutic interpersonal relationships. *American Journal of Public Health and the Nations Health*, 57(10), 1778-1791.
- Vitolins, M., Rand, C., Rapp, S., Ribisl, P., & Sevick, M. (2000). Measuring Adherence to Behavioral and Medical Interventions. *Controlled Clinical Trials*, 21(5), S188-S194. [https://doi.org/10.1016/s0197-2456\(00\)00077-5](https://doi.org/10.1016/s0197-2456(00)00077-5)
- Watson, J., & Prosser, M. (2002). Development of an observer rated measure of therapist empathy. In J. Watson, R. Goldman & M. Warner, *Client-centered and experiential psychotherapy in the 21st century: Advances in theory, research and practice* (pp. 303-314). Ross-on-Wye: PCCS Books.

- Webb, C. A., Derubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 200–211. <https://doi.org/10.1037/a0018912>
- Westwell, G., Elliott, R., Freire, E. (2012) *How well do PCEPS raters agree with client and therapist perceptions of the relationship?: A convergent validity study*. 10th World Conference for Person-Centred and Experiential Psychotherapy and Counselling 2012, Antwerp, Belgium. https://www.researchgate.net/publication/235735804_Person_Centred_and_Experiential_Psychotherapy_Scale_Field_trial_results_and_next_steps
- Westwell, G., Freire, E., & Elliott, R. (2011). *The Person Centred and Experiential Psychotherapy Scale (PCEPS)*. Joint conference of the British Association for Counselling & Psychotherapy and the UK Chapter of the Society for Psychotherapy Research 2011, Liverpool, UK.

Tables

Table 1:

Distribution of PCEPS-YP individual mean ratings

Individual mean PCEPS-YP ratings	Frequency (n)
1.0 – 1.99	1 (0.4%)
2.0 – 2.99	9 (3.2%)
3.0 – 3.99	42 (14.8%)
4.0 – 4.99	126 (44.4%)
5.0 – 5.99	100 (35.2%)
6.0	6 (2.1%)
< 3.5 cut-off	28 (9.9%)
≥ 3.5 cut-off	256 (90.1%)

Table 2: Cronbach's Alpha, Pearson's Correlations, Means, Standard Deviations and Factor Loadings for PCEPS-YP – items and mean scale score.

	Cronbach α		Pearson's correlation (r)	Mean (SD)	Factor loading
	Paired raters	Grouped raters	Paired raters		Factor 1
1 Frame of reference	.42	.32	.27*	4.7 (0.9)	.85
2 Tracking	.42	.18	.27*	4.9 (0.9)	.80
3 Empathic resonance	.50	.58	.33*	4.5 (0.9)	.88
4 Accepting presence	.47	.50	.31*	5.1 (0.7)	.74
5 Genuineness	.39	.51	.24*	4.8 (0.9)	.82
6 Emotion focus	.39	.50	.25*	4.3 (1.1)	.82
7 Emotion symbolisation	.44	.56	.29*	4.0 (1.2)	.81
8 Facilitation	.36	.53	.22*	4.3 (1.0)	.85
9 Developmental Responsiveness	.30	.47	.18*	4.7 (0.9)	.78
PCEPS-YP Mean Score	.50	.58	.34*	4.6 (0.8)	
N	142	19	142	284	

*Correlation is significant at $p < 0.05$.

Table 3: Corrected item-total correlations and item intercorrelations (n = 284 individual segment ratings)

	Corrected Item-Total correlations	Item intercorrelations							
		1_Fram eRef	2_Tracki ng	3_Empa thy	4_Accep tance	5_Genui neness	6_Emoti onfocus	7_Emoti onsym	8_FacD ev
1_FrameRef	.82								
2_Tracking	.77	.76							
3_Empathy	.85	.77	.68						
4_Acceptance	.72	.63	.68	.66					
5_Genuineness	.78	.68	.69	.69	.73				
6_Emotionfocus	.81	.69	.60	.73	.52	.61			
7_Emotionsym	.79	.65	.56	.73	.53	.59	.85		
8_FacDev	.83	.71	.63	.74	.56	.68	.78	.78	
9_DevelApp	.75	.65	.68	.69	.62	.68	.59	.58	.64

Table 4: Summary of analyses performed.

Analysis	Reported statistics	Data (all use unadjusted ratings)
Descriptive Analyses		284 individual item ratings taken from the PCEPS-YP across all raters.
Internal consistency	Cronbach's alpha, item correlations	284 individual item ratings taken from the PCEPS-YP across all raters.
Interrater reliability	Cronbach's alpha and Pearson's correlations	19 grouped ratings for each counsellor, across raters, analysed for PCEPS-YP scale items and mean ratings. 142 paired ratings, analysed for PCEPS-YP scale items and mean ratings.
Construct validity	Eigenvalues and factor loading	284 individual item ratings on the PCEPS-YP items, across all raters.
Convergent validity	Pearson's correlations	BLRI-Obs 40 and PCEPS-YP ratings of 50 segments by one rater.

Appendix 1 (PCEPS-YP instrument)

**PERSON-CENTRED & EXPERIENTIAL PSYCHOTHERAPY SCALE – Young
Person Counselling Version (PCEPS-YP) (Version 18.8.16)** (© 2016 Susan
McGinnis & Robert Elliott. Permission is granted to reproduce this form for educational,
training, or supervision purposes, on the condition that it is not changed or sold).

Client ID _____ Session _____

Rater _____ Segment _____

Rate the items according to how well each activity occurred during the therapy segment you've just listened to. It is important to attend to your overall sense of the therapist's level of skill. Try to avoid forming a 'global impression' of the therapist early on in the segment.

1. CLIENT FRAME OF REFERENCE:

How much do the therapist's responses convey an understanding of the client's frame of reference (i.e., their world view) and the ways in which the young person understands themselves within it?

Do the therapist's responses convey an understanding of the client's inner world, as immediately expressed by the client? Or, conversely, is the therapist only able to respond from their own frame of reference?

- | |
|---|
| <ol style="list-style-type: none">1. No understanding: 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 understanding: 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. Slight understanding: Therapist's responses begin to approach an adequate understanding of the client's frame of reference but are consistently somewhat 'off'.4. Adequate understanding: Therapist's responses convey an adequate understanding of the client's frame of reference.5. Good understanding: Therapist's responses convey a good understanding of the client's frame of reference.6. Excellent understanding: Therapists' responses convey an accurate understanding of the client's frame of reference and therapist adds no meaning from their own frame of reference. |
|---|

2. TRACKING:

To what extent is the therapist following the client's track?

Are the therapist's responses closely following the client's expressed thoughts, feelings and story? While following the client's track, is the therapist able to check and responsively revise their perceptions of the client's world view based on client feedback?

Conversely, are the therapist's responses a diversion from the client's own train of thoughts and feelings? Is the therapist inflexible in their perspective?

1. **No tracking:** Therapist responses do not follow the client's track at all, or they divert client from their thoughts/feelings; therapist fails to check their perceptions against client's own experience.
2. **Minimal tracking:** Therapist is only occasionally on client's track; therapist fails to check their perceptions against client's own experience.
3. **Slight tracking:** Therapist tries to track client but often fails to do so accurately; only occasionally checks their perceptions against client's own experience.
4. **Adequate tracking:** Therapist is adequately on client's track, checking their perceptions with client and showing ability to revise their understanding based on client feedback.
5. **Good tracking:** Therapist responses consistently follow the client's track; therapist checks and revises their perceptions of the client's experience based on client feedback.
6. **Excellent tracking:** Therapist is sensitively and actively follows the client's track, quickly and flexibly responding and revising perceptions based on client feedback.

3. EMPATHIC RESONANCE:

How well is the therapist able to resonate with, and communicate their understanding of, the young person's spoken and unspoken feelings and perceptions?

How accurate and consistent is the therapist's understanding of the client's inner world? Is the therapist able to tune into, and reflect back, the young person's unspoken or non-verbal communication such as body language or tone of voice (when this is possible to observe) in addition to the client's verbally expressed feelings and thoughts?

Conversely, to what extent does the therapist miss or dismiss the client's feelings, or assume the client shares their feelings?

1. **No resonance:** Therapist consistently misses or dismisses client feelings and perceptions; makes assumptions based on therapist's own perceptions and is completely out of tune with the client.
2. **Minimal resonance:** Therapist is only occasionally and inconsistently able to communicate client feelings and perceptions back to them, with their responses typically based on therapist's own feelings.
3. **Slight resonance:** Therapist communicates understanding of some of the client's feelings and perceptions, without fully resonating with them..
4. **Adequate resonance:** Therapist is generally able to resonate with, and communicate accurate understanding of, client's feelings and perceptions.
5. **Good resonance:** Therapist is consistently and accurately attuned to the client and clearly communicates their understanding of the client's spoken and unspoken feelings.
6. **Excellent resonance:** Therapist is especially in tune with the client and capable of deeply sensing, and resonating with, the feelings that are both unspoken and spoken.

4. ACCEPTING PRESENCE:

Do the therapist's responses convey a fundamentally accepting attitude toward the young person?

How well does the therapist's attitude convey acceptance of the young person's world view regardless of their behaviour, attitudes and beliefs?

How well do the therapist's way of being and tone of voice convey genuine acceptance to the young person?

To what degree is the therapist able to hold a consistent welcoming and non-judgmental attitude?

1. **Explicit nonacceptance:** Therapist explicitly communicates disapproval or criticism of client's experience/meaning/feelings.
2. **Implicit nonacceptance:** Therapist implicitly or indirectly communicates disapproval or criticism of client's experience/meaning/feelings.
3. **Incongruent/inconsistent nonacceptance:** Therapist acceptance is inconsistent and slightly judgmental.
4. **Adequate acceptance:** Therapist demonstrates at least some degree of acceptance of the client's experience.
5. **Good acceptance:** Therapist clearly conveys unconditional acceptance, even in face of the client's challenging behaviours or thoughts.
6. **Excellent acceptance:** Therapist skilfully conveys clear, grounded acceptance of the client's experience and does not demonstrate any kind of judgment towards client experiences or behaviours, even when these might be criticised by others.

5. GENUINENESS:

How well does the therapist respond in a way that genuinely and naturally conveys their moment to moment experiencing of the client?

How much is the therapist able to relate to the young person without adopting a professional façade? Does the therapist sound artificial, overly professional, formal, stiff, pedantic or affected vs. genuine, idiosyncratic, natural or real?

Is the therapist able to relate to the young person in a genuine person-to-person manner? Or, conversely, is the therapist patronising or parental in their responses?

To what degree is the therapist able to skilfully express their congruent experience of the young person in a facilitative manner?

- | |
|--|
| <p>1 No genuineness: Therapist sounds completely fake, artificial or patronising and does not seem aware of their own experiencing of the client.</p> <p>2 Minimal genuineness: Therapist sounds somewhat wooden, stiff, formal or technical; unable to relate in a person-to-person manner with the client.</p> <p>3 Slight genuineness: Therapist sounds a little distant or affected and only occasionally aware of their own experiencing of the client; rarely able to connect to the client in a person-to-person manner.</p> <p>4 Adequate genuineness: Therapist generally sounds natural, unaffected and able to some degree to maintain a person-to-person stance; some congruence with occasional lapses.</p> <p>5 Good genuineness: Therapist sounds consistently natural or genuine, in touch with their experiencing of the client at a person-to-person level, and expresses this in a facilitative manner.</p> <p>6 Excellent genuineness: Therapist sounds completely genuine, very real or personally present, without any façade or pretence; comfortably, sensitively and appropriately conveys their experience of the client in a person-to-person manner.</p> |
|--|

6. EMOTION FOCUS

How much does the therapist actively work to help the young person focus on their emotional experiences and meanings, both explicit and implicit?

Does the therapist facilitate the client to:

- *focus their attention inwards in order to become more aware of their feelings?*
- *focus their attention on bodily sensations?*
- *reflect toward emotionally poignant content?*
- *intensify, heighten, evoke or deepen their emotions?*

Does the therapist help by:

- *responding to explicit or implied emotional content in what the young person is saying or doing?*
- *making empathic conjectures about feelings that have not yet been expressed?*
- *enquiring about client feelings?*

Lower scores reflect ignoring implicit or explicit emotions; staying with non-emotional content; focusing on or reflecting generalised emotional states ('feeling bad') or minimising or downplaying emotional states (e.g., reflecting 'angry' as 'annoyed'); failing to recognise, or ignoring, the young person's attempt to verbalise a feeling.

- 1. No emotion focus:** Therapist consistently ignores emotions or responds instead in a highly intellectual manner while focusing entirely on non-emotional content. When the client expresses emotions, the therapist consistently deflects the client away from them.
- 2. Minimal emotion focus:** Therapist seems to have a concept of emotion focus but doesn't implement adequately, consistently or well; therapist may generally stay with non-emotional content; sometimes deflects client away from their emotion; reflects only general emotional states ('bad') or minimises client emotion.
- 3. Slight emotion focus:** Therapist often ignores or deflects client away from emotion; therapist only slightly or occasionally helps client to focus on emotion; while they sometimes respond in a way that points to client emotions, at times they fail to do so, or do so in an awkward manner.
- 4. Adequate emotion focus:** Therapist generally encourages client focus on emotions (by either reflections or other responses), with only minor, temporary lapses or slight awkwardness.
- 5. Good emotion focus:** Therapist does enough of this and does it skilfully and sensitively, trying to help the client to evoke, deepen and express particular emotions.
- 6 Excellent emotion focus:** Therapist does this consistently, skilfully, and even creatively where appropriate, offering the client powerful, evocative reflections or questions, while at the same time enabling the client to feel safe while doing so.

7. EMOTION SYMBOLISATION

How well does the therapist assist the young person to articulate emotions and experiences?

How skilful is the therapist in facilitating the young person to:

- *find appropriate words to describe their emotions, especially those that seem difficult to access?*
- *verbalise the concerns, meanings and memories which emerge out of emotional arousal?*
- *identify and verbalise the wishes, needs, behaviours and goals associated with feelings and emotions?*

Is the therapist able to offer imagery and metaphor to help the young person accurately articulate the meaning of their experiences?

- 1. No emotion symbolisation:** Therapist imposes own language on the client, anticipates and assumes client's meaning and leaves things unexpressed; does not attempt to help client symbolise experience.
- 2. Minimal emotion symbolisation:** Therapist attempts minimally to facilitate the client's symbolisation of their difficult-to-access feelings and experience but lacks patience and misses the underlying meanings and needs.
- 3. Slight emotion symbolisation:** Therapist is able to facilitate the client's symbolisation of emotion and other experiences to some degree but is inconsistent and mostly unimaginative in their approach; has slight sensitivity to underlying meanings and needs.
- 4. Adequate emotion symbolisation:** Therapist is generally able to facilitate client symbolisation of emotion and experiences in a patient manner.
- 5. Good emotion symbolisation:** Therapist is skilful and imaginative in facilitating client emotions and experiences and communicates patience when feelings are difficult to symbolise; helps client to identify and express the needs and concerns associated with their emotions.
- 6. Excellent emotion focus:** Therapist is especially sensitive to the client's pace in symbolising emotions and other experiences; works closely and creatively with the client to fine-tune the expression of even difficult-to-access experience and emotion so that understanding matches symbolisation.

8. FACILITATION OF CLIENT SELF-DEVELOPMENT

How much does the therapist actively work to facilitate new client awareness, growth, perspectives and narratives?

Does the therapist:

- *recognise, support, or symbolise emerging new client emotions or other experiences?*
- *facilitate the young person to translate new perspectives into alternative ways of understanding their experiences and actions?*
- *facilitate the young person to develop new narratives about themselves and their world?*

Lower ratings are used when the therapist ignores new awareness, insight or shifts in perspective or behaviour.

<p>1 No facilitation: Therapist either fails to recognise, or consistently ignores new client awareness or new perspectives; generally responds instead to client despair or stuckness in recycling old narratives. When the client expresses new, emerging experiences, the therapist consistently deflects the client away from them.</p> <p>2 Minimal facilitation: Therapist occasionally recognises emerging new client perspectives and narratives but fails to facilitate the client to explore or develop them.</p> <p>3 Slight facilitation: Therapist recognises emerging new client perspectives and narratives but their attempts at facilitating client exploration and development are awkward, ineffective or, conversely, directive.</p> <p>4 Adequate facilitation: Where appropriate, therapist generally recognises and encourages exploration of emerging client experiences or new narratives and actions (by either reflections or other responses), with only minor, temporary lapses or slight awkwardness.</p> <p>5 Good facilitation: Therapist recognises and skilfully supports emerging new perspectives; where appropriate, offers responses that facilitate the young person to translate new perspectives into alternative understandings or actions. Implicitly convey trust in the client's self-development potential.</p> <p>6 Excellent facilitation: Therapist works consistently, skilfully, even creatively, where appropriate, to highlight, and facilitate the client to explore, emerging new perspectives and any subsequent alternative understandings or actions; therapist may do this by offering client choices or implicitly or explicitly communicating trust in the client's self-development process.</p>
--

9. DEVELOPMENTAL RESPONSIVENESS

How skilful is the therapist in adapting to the young person's individual developmental levels in relation to language, thinking and understanding, expression of affect and behaviour?

Is the therapist able to communicate at a developmentally appropriate level while respecting the young person's emotional, communicative and self-reflective capacities, as opposed to talking over the young person's head or patronising them?

Is the therapist able to employ, where appropriate, a range of symbolic communication modes consistent with the young person's developmental level, e.g., drawing, play or other creative methods?

1. Is the therapist able to understand and work with the client's developmentally appropriate modes of expressing emotion even when these may be challenging? For example, does the therapist respond with empathy and acceptance when the young person expresses themselves in ways that might be considered unacceptable in another context (within limits of safety for both client and therapist).

Conversely, does the therapist inflexibly insist on adult ways of communicating and acting, or underestimate the client's capacities and expect something too childish?

1. **No developmental responsiveness:** Therapist does not adapt to the developmental capacity of the client in any way; offers no alternative methods of communication or symbolisation aside from talking; is unable to tolerate expression of client feelings outside of the 'acceptable' adult range.
2. **Minimal developmental responsiveness:** Therapist attempts to respond at the appropriate developmental level but is unable to do so adequately, consistently or well; sounds awkward, stilted, uncomfortable or patronising in adapting their language or way of working with the young person.
3. **Slight developmental responsiveness:** Therapist is somewhat able to respond to the young person's developmental capacity but is slightly 'off' e.g. trying too hard or overestimating the young person's developmental level.
4. **Adequate developmental responsiveness:** Therapist is mostly sensitive to, and able to respond appropriately to, the client's developmental capacity through language and creative methods of symbolising experience; therapist shows some ability to empathise with and accept challenging, but developmentally appropriate, client actions and feelings.
5. **Good developmental responsiveness:** Therapist consistently matches client's developmental capacity through language and creative methods of symbolising experience; they respond non-defensively and openly to challenging but developmentally appropriate client feelings and actions.
6. **Excellent developmental responsiveness:** Therapist's responses are comfortably, consistently, and intuitively matched with the client's developmental capacities; therapist shows an understanding of the meaning in the client's developmentally appropriate feelings and actions, even when these are challenging or puzzling.