The effects of therapist training and experience on the outcomes of psychological therapy within an NHS setting

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Mandy Newman, BSc. (Hons), PgDip, MBPsS

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The effects of therapist training and experience on the outcome of psychological therapy within an NHS setting

Committee:

Dr. Naomi Moller

Dr. Paul Redford
THE EFFECTS OF THERAPIST TRAINING AND EXPERIENCE ON THE OUTCOMES OF PSYCHOLOGICAL THERAPY WITHIN AN NHS SETTING

Abstract

Background: This study is based on the notion that client therapy outcomes are dependent, in part, on who the therapist is and not on the techniques they use or what theoretical model is drawn upon to conceptualise the presenting difficulties. Research going back decades has shown that some therapists are better than others at gaining positive outcomes. Additionally, a range of specific therapist characteristics have been shown to contribute to such outcomes. However, the two most controversial variables to have been investigated are therapist training and level of experience; to date the research findings have not clearly demonstrated that either training or experience make a practitioner more effective with clients. This study thus set out to explore the differences in effectiveness between therapists on client outcomes in the context of a British, NHS setting. In addition to this, the study also investigated the specific effects of therapist training and experience.

Methodology: This study examined data collected on 109 clients seen by 9 therapists over a five year period. The study incorporated client pre and post scores on the Clinical Outcomes in Routine Evaluation questionnaire (CORE: CORE Systems Group, 1998), and therapist information obtained from an ‘in service audit questionnaire’. A series of Analysis of Co-variances (ANCOVA) were conducted.

Results and Discussion: The study findings showed that there were no statistically significant differences between the therapist’s levels of effectiveness. This result indicates that each of the therapists were as equally effective in gaining positive outcomes.
Additionally, no statistical support was gained for the influence of either therapist training or experience on therapeutic outcomes. The implications of the study findings as well as the study limitations and directions for future research are discussed.
Dedication

To my beautiful children Corey, Lauren and Kayleigh for their patience, understanding and support, without which completion of this report would not have been possible.
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Introduction

In the literature review, it will be argued that client therapy outcomes are dependent, in part, on who the therapist is and not on the type of techniques delivered or what theoretical model is used to conceptualise the presenting difficulties. This dissertation suggests however that this truth has been forgotten because, due to evolutionary developments such as pressures to develop policies and guidelines for managed care systems (e.g. Task Force on Promotion and Dissemination of Psychological Procedures, 1995), scientific investigations into the role of therapist characteristics or ‘common factors’ have declined while investigations into the ‘efficacy’ of different therapies have dominated (e.g. Garfield, 1997). Efficacy studies (Randomised Control Trials: RCT’s), by design, implement strict and rigorous training and supervisory processes, all of which are intended to ‘eliminate’ therapist effects and in turn maximise the power of treatments. Yet RCT’s have shown that empirically supported therapies such as psychodynamic and cognitive-behavioural therapy are more or less equal in their level of effectiveness, a finding which has become known as the ‘Dodo bird’ effect (‘All have won and all shall have prizes’, Stiles, Shapiro, and Elliott, 1986). In addition the highly significant results found in RCT’s have not been found in ‘real world’ settings which may indicate that ‘research therapy’ is more effective than therapy undertaken within every day practice (Shadish, Matt, Navarro, and Phillips, 2000). Equally, and of considerable clinical significance, despite the rigorous criteria of RCT’s, differences in client outcomes due to therapist effects have continued to be found (e.g. Kim, Wampold, and Bolt, 2006) and thus, presumably, therapist variability in effectiveness would be even higher within every day practice. Therefore, is argued that conducting research focussed exclusively upon therapist’s variability and specifically within
a ‘real world’ setting is imperative to developing an understanding of the true nature and influence of therapist effects on client therapy outcomes.

Of the limited studies to date, it has been shown that the effects of individual therapists vary between negligible in some studies to a large and significant proportion of the outcome in others, evidencing a range from 0% to 50% (Critis-Christoph and Mintz, 1991). What can be concluded from these results is that the contribution of therapist effects may overshadow differences between different forms of treatments and hence that the need for further research in this area should not be ignored (e.g. Luborsky, Critis-Christoph, McLellan, Woody, Piper, Liberman, et al., 1986). Furthermore, it will be argued that understanding therapist effects is of central importance for training purposes, service delivery, client well being and, imperatively, to maintain ethical standards of practice (e.g. BACP, 2010).

This dissertation highlights that research in this area initially treated the construct of ‘therapist effects’ as a global variable. However, ‘the therapist’ factor is not one unitary thing but constitutes a complex array of variables. Therefore, with growing recognition of such complexities and in line with the developments in this area, the following study will also focus upon investigating ‘specific’ therapist characteristics and their contribution to therapy outcome.

A range of therapist variables have been studied. These include but are not limited to: therapist age (e.g. Beck, 1988), sex (e.g. Krippner and Hutchinson, 1990), and personality traits (e.g. Berry and Sipps, 1991). However, the two most controversial variables to have been investigated are therapist’s training and level of experience (e.g. Beutler, 2004). Throughout the training and experience literature, a developing ‘tentative’ trend in support of the influence of these variables has been evidenced (e.g. Bergin, 1971; Stein and Lambert,
Simultaneously however, progression in this area of study has been hampered by a range of issues. These include, for example, inconsistencies in the methods and tools used to measure outcome which in turn makes comparisons of the findings problematic (e.g. Barkham, Stiles, Hardy and Field, 1996). Further to this, many studies have been unable to provide accurate findings of variability due to failing to include therapists with diverse levels of training and lengths of experience (e.g. Fals-Stewart and Birchler, 2002; Stein and Lambert, 1984). Additionally, it is suggested that such controversial findings have been due to the use of varying statistical techniques (e.g. Hox, 2010), and specifically, the ways data have been organised and analysed within these statistical analyses. For example, treating therapists as fixed or random variables and not including three levels of data: client, therapist and therapy (e.g. Kim, Wampold and Bolt, 2006). Thus, such identified methodological and statistical issues need to be considered in all future research in order to advance understanding of this critical but conflicted area of study.

In light of these findings, the following study explored the amount of variance or differences in effectiveness between therapists on client outcomes in the context of a British, NHS naturalistic setting. Further, an investigation into therapists’ training and level of experience was also undertaken in order to enhance current understanding of the true nature and impact of these specific characteristics upon outcome variability. The study was retrospective in design. It encompassed 109 client-therapist data sets, collected as part of ‘business as usual’ processes over a five year period between 2007 and 2012. To counteract some of the identified methodological and statistical difficulties and in turn build upon the current literature base, the outcome measure used in the study was a commonly used and validated benchmarking tool: the Clinical Outcomes in Routine Evaluation (CORE Systems
Group, 1998). Further to this, the therapist sample incorporated members of staff with a range of training levels and lengths of clinical experience. The study aimed to answer two questions: what amount of client outcome variability is attributable to therapist effects? What are the effects of a) therapist training and b) experience upon client outcomes?
Theoretical overview

It has long been shown that the ‘person of the therapist’ is considerably influential upon the therapeutic relationship, the change process, and on outcomes (Orlinsky, Ronnestad and Willutzti, 2003). These findings demonstrate the importance of understanding the ‘person of the therapist’ in terms of their personal qualities and skills, training, and experiential development (e.g. Neufeldt, 1999). The next section will discuss in turn some of the theoretical underpinnings of each of these issues.

The person of the therapist

Initial attempts to understand the person of the therapist was undertaken from a skills acquisition perspective (see Larson, 1984), which sought to enumerate the qualities of a good therapist such as listening skills or the ability to make empathic reflections. However, viewing the therapist from a skills perspective is problematic as it fails to take account of the therapist as a whole person; for example McLeod (2003) has argued that many of the essential qualities of the therapist are internal, unobservable processes. McLeod (2003) states as an illustration that a good therapist is potentially someone that is aware of their personal feelings with individual clients, who is also aware of the impact of those feelings upon the therapeutic relationship; neither capacity fits within the skills perspective. Additionally, the skills approach conflicts with the notion that personal qualities such as genuineness or presence are of central importance to the therapeutic process (McLeod, 2003). Thus, the skills approach to understanding ‘the therapist’ is clearly too narrow.

It has been suggested that an alternative and more desirable approach to understanding the person of the therapist is within the broader concept of ‘competence’ (McLeod, 2003). For
example, Crouch (1992) described competence as involving four areas of skill development: therapist awareness, personal work, theoretical understanding, and casework skills.

Simultaneously, Larson, Suzuki, Gillespie, et al. (1992) constructed a model of competence encompassing five areas of development: micro skills, process, and dealing with difficult client behaviour, cultural competence and awareness of values. As can be seen, both Crouch (1992) and Larson (1992) extensively build upon and broaden the initial views of the skills theorists, although neither independently provides a holistic account of competence: a common drawback of all theories. However, both theories are supported by extensive research, whereby several categories of therapist variables have been identified (Beutler, Crago and Arizmendi, 1986). Thus, it can be said that a holistic view of the therapist as a person would encompass personal qualities alongside an openness to developing theoretical understanding and an ability to apply their learning to practice such that the practitioner can demonstrate within their practice high standards of professional and ethical conduct (BPS, 1993).

A general theoretical framework that provides an understanding of the interpersonal aspects of competence is the ‘therapeutic alliance model’ (Bordin, 1979). This model emphasises three elements that are deemed important to developing a good therapeutic relationship: creation of an emotional bond, agreement on goals, and shared understanding of the tasks to be undertaken to achieve such goals. Thus, the model highlights processes that are deemed important in all therapeutic encounters, regardless of theoretical orientation (e.g. Beck, Rush, Shaw, and Emery, 1979).

Other theorists have drawn attention to dimensions of interpersonal relating abilities that contribute to alliance performance. For instance, Rogers (1957) proposed the facilitative
skills or ‘core conditions’ of empathy, congruence and acceptance. Additionally, Hobson (1985) suggested that the bond between the therapist and client is created through the process of a ‘shared feeling language’ or a way of talking together that allows the client to express their feelings. These theories clearly provide depth to the understanding of the therapist and their relational encounters, thus placing emphasis on not just the content of communication but also on how communication is accomplished.

The reviewed models provide a range of theoretical understanding of what being ‘good’ or ‘competent’ means for therapeutic practitioners. Looking across the models one can conclude that there is no definitive agreement on what skills or personal qualities a good therapist might have but that there is nonetheless a tendency to focus on competence in terms of skills, which can be taught or learned. This is relevant for the current project which includes a strong focus on training. Until this point, only theories alluding to ‘qualified’ therapists have been discussed. The next section provides an overview of some theories related to training and experience; the conceptual frameworks discussed share a focus on the importance of developing good/competent practitioners but their focus is not directly on ‘what’ is good (this is implicit) but instead on how a poor or incompetent or inexperienced practitioner can be aided to become experienced and competent.

Training

The key aim of training courses is to train practitioners to be ‘competent’ to undertake the task of professional practice (BPS, 1993). A number of theories have been proposed about how the movement towards competence occurs. For example, Brightman (1984) proposed that practitioners initially feel vulnerable, incompetent and experience fears of inadequacy. To manage such difficult emotional experiences however, a ‘grandiose professional self’ is
said to develop, whereby individuals identify with being all knowing, powerful and loving, and never admit to making mistakes (Jones, 1951). Further to this, as the trainee develops additional challenges around case management may arise and balancing tensions between therapeutic demand and capacity to meet these demands often follows. Such challenges, if not managed correctly can lead to therapists losing motivation to help and thus experiencing burnout (e.g. Kovacs, 1976). Arguably therefore, the provision of supervision and reflective practice would be deemed of critical importance throughout this developmental process to ensure that appropriate and ethical practice is undertaken (Brightman, 1984).

A general model often used to describe the development of competence in therapeutic training is the ‘conscious competence matrix’ (see Cully and Bond, 2009 p. 11). This model proposes that four distinct learning stages are undertaken to reach a high level of mastery:

- ‘unconscious incompetence’ (limited skill but unaware of lack of skill and therefore confidence will exceed abilities);
- ‘conscious incompetence’ (awareness of current skills and skills to be learned, such that realisation of the lack of current competence leads to a drop in confidence and an uncomfortable period);
- ‘conscious competence’ (new knowledge and skills acquired still requiring significant concentration to perform the activities but confidence is developing); and
- ‘unconscious competence’ (knowledge and skills are now habit and performed on ‘auto pilot’; the person is now at the peak of confidence and ability. However, complacency may then develop and in which case the cycle should being again.
This theory has a number of strengths. Firstly, identifying and understanding where someone is within their development helps inform further learning and supervision. Secondly, the theory not only relates to individuals in training but can also be related to and used with practitioners with various levels of experience and throughout the career span.

Theories of the development of therapeutic competence are important for any formal therapy training programme since logically the components in the training programme flow logically from an agreement on what needs to be developed and how that development should best be fostered.

One of the early training models was Rogers (1942, 1957) Person-Centred training in which the skills of the person-centred approach were integrated with additional behaviours that were associated with positive therapeutic outcomes (Carkhuff and Berenson, 1967). Skills-based models of training that encompassed very structured problem-solving skills that developed through stages, with each stage composed of a series of steps and related skills (Carkhuff and Anthony, 1979). The most influential of such models were: the Human Relations Training (HRT: Carkuff, 1969), the Skilled Helper Model (Egan, 1984), Micro-skills Training (MC: Ivey, 1971), and the Interpersonal Process Recall Model (IPR: Kagan, 1984). These models differed in some ways, for example, HRT and MC focused on teaching specific verbal skills whereas IPR focused on trainees articulating their thoughts and feelings about interventions to overcome performance anxiety. Nonetheless, all contained similarities in the form of providing structured handouts, exercises, and video demonstrations, each of which would take the trainee through a standard programme for learning specific therapeutic skills. Such commonalities led to a broad consensus within the Humanistic tradition as to what constitutes a good training programme (Dryden and Thorn 1991; Means
with commonly used interventions including modelling, practicing skills, feedback and supervision (Hill and Lent, 2006).

Behaviourist and CBT therapeutic approaches include their own understanding of training (BABCP, 2000). An example of this is the use of the Cognitive Therapy Rating Scale (Young and Beck, 1988) which is used in CBT training to assess trainee therapists’ level of competence with clients (Young and Beck, 1988). Assessment is focussed on CBT-relevant domains such as the ability to work with a client to set a productive agenda for the setting. This example further demonstrates the relationship between implicit understandings in each therapy approach about what effective therapists need to do and what the training programmes for each approach incorporate into their training.

Ideas about training have been influenced by pan-theoretical as well as orientation-specific understandings. One such is supervision. Supervision is increasingly included as a mandatory element within many training programmes (with trainee’s increasingly not just receiving clinical supervision in the course context but also being given training in delivering supervision) and is also seen as a critical element in ongoing clinical practice (e.g. Division of Counselling Psychology 1998; Mearns 1997; Thorn and Dryden 1991). Thus supervision is important beyond the formal training period, potentially being in part a form of work-based training.

**Supervision**

Supervision is described as a process that aims to help the therapist to work as effectively as possible with clients (Carroll, 1988), and provides the context for learning about professional practice (Jennings, 1996). Processes such as modelling, learning interviewing
techniques, setting boundaries, learning from mistakes, and discussing ethical concerns for example, are said to be important elements of supervision (Jennings, 1996).

 Supervision can be provided on an individual basis (one supervisor for all issues), or on an individual but area specific basis (specialist supervisors for different areas of practice), or on a group basis (e.g. Kaslow, 1986). Regardless of the style of supervision however, it is theorised that in any one supervisory session there are six levels of learning operating (Hawkins and Shohet, 1989, 2000): reflections on the content of therapy sessions, explorations of the techniques and strategies used by the therapist, exploration of the therapeutic relationship, feelings of the therapist towards the client, what is happening in the here and now between supervisor and supervisee, and counter-transference of the supervisor. It is proposed that good supervision will involve movement between each of these stages. However, each supervisor may develop their own style and thus operate on selected levels (e.g. Hawkins and Shohut, 1991).

 Each mode of supervision has its advantages and disadvantages (e.g. McLeod, 2003). For example, individual supervision promotes the development of a good working relationship. Specialist supervision with a range of supervisors on the other hand can provide more in-depth and specialist knowledge. On a group basis, it can be said that supervisees gain learning experiences from the range of cases presented and opinions shared within the group. In contrast however, group supervision for example, can generate problems with confidentiality. Additionally, group dynamics can be troublesome and difficult to manage. The overall choice of supervision type however, can often depend on a range of factors such as personal preference, availability and organisational policies (e.g. McLeod, 2003).
Of the large number of supervision models developed (e.g. Ronnestad and Skovholt, 2003; and Stoltenberg, McNeill, and Delworth, 1998), The Hawkins and Shohet (1989, 2000) model has been widely used in training programmes (McLeod, 2003). However, a model that pays particular attention to a ‘reflective space’, and thus allows for the interconnection between theory and practice (Schon, 1983) is the ‘Cyclical model developed by Page and Wosket (2001). This model proposes that supervision can be divided into five stages that are cyclical and leads to the strengthening of the supervisory relationship: establishing a contract, agreeing a focus, making a space, making a link between supervision and practice, and review and evaluation.

One may argue that the model proposed by Page and Wosket (2001) is the more robust as it incorporates reflective practice. Thus, reflection has been shown to play a key role in distinguishing between expert and average therapists (e.g. Bennett-Levy, Lee, Travers, Pohlman and Hamerik, 2003). Additionally, as Skovholt, Ronnestad, and Jennings (1997, p.365) wrote: ‘A therapist can have 20 years experience or one year of experience 20 times. What makes the difference? A key component is reflection’. That being said, the Hawkins and Shohel (1989, 2000) and Page and Wosket (2001) models can be seen as complementary theories of supervision as the first emphasised what is learnt and the second highlights the process within which such learning takes place. However, both models are limited in that they only focus on individual supervisory sessions. Thus, longer-term processes and the overall developmental stage of the therapists are not accounted for, as therapists of different levels of skill and experience have different supervisory needs (McLeod, 2003).
Consequently, numerous models have been devised to account for such long-term developmental processes (see Stoltenberg and Delworth (1987) for a review). One such model by Friedman and Kaslow (1986) proposed that six stages of development are undertaken over a several year period: excitement and anticipatory anxiety (a guidance phase before the therapist has seen their first client); dependency and identification (clients have been met but lack of skill and competence of the therapists results in a degree of dependency on the supervisor. The personality and dynamics of the client and not the therapeutic relationship are the focus of work in this stage); activity and continued dependency (therapist realises that they are making a difference to clients and become more active with different strategies and techniques. The therapists’ level of self awareness is also developing and becoming part of supervision); exuberance and taking charge (the therapist is now making connections between theory and practice. A single theoretical orientation is also developing. Transferential issues are discussed and the supervisor is no longer seen as a teacher); identity and independence (the stage of ‘professional adolescence’ where the therapist is more able and willing to give differences of opinions. An internal frame of reference has developed and advice can be accepted or rejected. The therapist skills may exceed those of the supervisor and thus the supervisor no longer has control); and calm and collegiality (the therapist has developed a firm sense of identity and competence. The therapist may also take an interest in taking on the supervisory role).

In their model Friedman and Kaslow (1986) clearly highlights that as therapists move through these developmental stages, the focus and needs of supervision can be qualitatively different. Awareness of such differences and in turn individual needs can ultimately direct and focus interactions and expectations accordingly. Additionally, throughout the model,
the quality of the relationship is rightly deemed of central importance (Shohet and Wilmot, 1991).

Summary

It has been suggested that the more desirable way to conceptualise ‘the person of the therapist’ is through the concept of competence (e.g. Crouch, 1992). A number of training models have been developed to enable practitioners to gain competence in their theoretical knowledge, skills, and overall clinical practice. Some of the most influential training models have been briefly discussed and each were seen to exhibit some commonalities such as using modelling, feedback and supervision (Hill and Lent, 2006). Supervision is arguably a critical element of both training and practice (Division of Counselling Psychology, 1998), and thus a small number of supervisory models were also considered. These models not only highlighted important aspects of the supervisee’s experiential development and learning but also presented valuable guidance for the supervisor in terms of for example, understanding at which stage of development the supervisee is at and informing appropriate levels of supervisory guidance. The reviewed theoretical understandings of what a ‘good’ or ‘competent’ therapist looks like and how competence is or should be developed through training programmes and supervision are important in order to understand the empirical literature on therapist training and experience. However another area of theory is also relevant for any argument that the person of the therapist is an important contributor to positive changes in clients: the therapeutic relationship.
The Therapeutic Relationship

The therapeutic relationship is theorised to play a central role in producing effective therapeutic change (e.g. Horvath and Symonds, 1991), and the quality of the relationship has been shown to be a strong predictor of outcomes (e.g. Beutler, 1994). Arguably therefore, within outcome research, considering the factors that contribute to the relationship is of paramount importance.

Different therapeutic approaches conceptualise and use the therapeutic relationship in different ways (Clarkson, 1990) but they typically all acknowledge the importance of the relationship. The psychodynamic tradition for example, views the relationship as a ‘container’ or ‘vehicle for emotional learning (e.g. Strupp, 1969): within which, contemporary therapists work with transferential processes in a reciprocal or ‘two-person field (Gill, 1994). In contrast, the person centred school of thought emphasises the ‘presence’ of the therapist with the client in order to initiate the ‘necessary and sufficient conditions’ for therapeutic change or what are known as the ‘core conditions’ of empathy, warmth and congruence (e.g. Rogers, 1959). Cognitive-behavioural therapists also value the core conditions as necessary. However, they do not view them as ‘sufficient’ for change (Beck, Rush, Shaw and Emery, 1979): instead, a collaborative relationship in which the therapist has considerable skill and expertise is regarded as a further necessary factor (Beck et al., 1979).

The common acknowledgment of the importance of the therapeutic relationship means that, the relationship that develops between therapist and client is seen to be a key ‘common factor’ to all therapeutic models that determines therapeutic effectiveness (Orlinsky, Grawe, and Parks, 1994). Therefore in therapy, the therapist and client work
together to solve the client’s problems: a working relationship that unites the two individuals, in which, neither client nor therapist can succeed in gaining a positive outcome alone (Beck, et al., 1979b). It is argued therefore, that to truly understand therapeutic outcomes, the influence of both domains, client and therapist, must be investigated.

Numerous studies investigating the influence of client factors upon outcome have been undertaken (e.g. see reviews of client characteristics in Castonguary and Beutler, 2006b; Clarkin and Levy, 2004). In relative terms however, only a small number of studies have directly investigated therapist effects upon outcome thus, this area of research urgently requires further attention (Garfield, 1997). The next section reviews the research to date with a special focus on the therapist variables of training and experience.

**Therapeutic outcomes: Why it is important to investigate therapist effects?**

In a pioneering study Ricks (1974) conducted a follow-up investigation of a group of adolescent males that were initially seen by one of two therapists during their early childhood. It was found that both therapists were equally effective with less distressed individuals but this equivalence was not found for the more distressed boys. Further Ricks explained the differential effectiveness of the therapists in relation to their personal and interpersonal qualities. Thus, therapist A, the ‘supershink’ had effective interpersonal qualities such as investing more time, being firm, direct and consistent, and had strong alliances. Conversely, therapist B, the ‘pseudoshrink’, had poor personal qualities demonstrated by less invested time, was frightened by pathology, becoming depressed with difficult cases and feeling hopeless about outcomes ((Najavits and Strupp, 1994).

This study demonstrated in a dramatic fashion the potential importance of the person of the therapist and in response to Ricks (1974), a new wave of research was initiated as the study
was seen to highlight the importance of understanding such influences for training purposes, service delivery and overall client well-being.
Review of the empirical literature

The contribution of ‘the therapist’ to therapy outcomes

This dissertation assumes that some therapists are better than others at facilitating change and producing positive outcomes (Albert, 1997; Jennings and Skovholt, 1999), yet the lack of research means little is known about such outcome differences. The next section discusses the research conducted to date.

In one early study, Orlinsky and Howard (1980) examined the outcomes of 143 clients seen by 23 therapists. It was found that six of the therapists achieved outstanding outcomes, with none of their clients deteriorating. Conversely, five of the therapists had clients with low improvement rates and more than 10% were worse at termination. Similarly, Luborsky, McLellan, Diguer, et al. (1997) reported that the range of improvement for 22 therapists was between ‘slightly negative’ to ‘slightly’ more than 80% improvement. In contrast, Huppert, Bufka, Barlow, Gorman, and Shear (2001) investigated the relationship between therapists and outcome in the Multicentre Collaborative Study for the treatment of panic disorder and found smaller effect sizes ranging between 1% and 18%.

More recently, Okiishi, Lambert, Nielson, Benjamin, and Ogles (2003), completed a large scale study involving 1841 clients seen by 91 therapists within a University Counselling Centre. Results showed a significant amount in variations of client outcomes dependent upon therapist. Thus, clients seen by the more effective therapists showed a faster rate of improvement and had an average rate of change that was 10 times greater than the sample mean. Additionally, the therapists whose clients showed the slowest rate of change also experienced an average increase of symptomology at the end of therapy. These results may
explain the more general finding that between 5-10% of clients deteriorate in therapy (e.g. Laborsky et al., 1997). Overall however, these findings clearly indicate the impact of therapist effectiveness upon whether clients get better and experience an improved sense of well-being.

In a meta-analytic review of this literature, Critis-Christoph and Mintz (1991) reported that the effects of individual therapists varied between negligible in some studies to a large and significant proportion of the outcome in others. The authors concluded that therapist effects ranged from 0% to 50%, with a mean of 8.6%. Thus, over and above the diverse range of variances reported, what can be concluded is that the contribution of individual therapist effects ‘generally overshadows any differences between different forms of treatments’ (Luborsky, et al., 1986, p.509) and should not be ignored (Critis-Christoph and Mintz, 1991).

**Factors contributing to mixed findings between studies: statistical issues**

While there is strong evidence that therapist effects do exist, the fact that some studies have found no evidence of such begs questions. One potential explanatory factor for the mixed findings is the use of differing statistical techniques between studies (e.g. Hox, 2010). In response, more recent investigations have used multilevel modelling strategies, also known as multilevel (e.g. Heck and Thomas, 2000) or mixed effects models (Pinheiro and Bates, 2000). Such statistical approaches allow analysis of unequal sample sizes and ‘nested’ data, which is the multi-level data of multiple therapists, each of whom has their own clients (see e.g. Raudenbush and Bryk, 2002). However, despite this increase in statistical sophistication in the field, findings continue to vary. In two exemplary studies, Elkin, Falconnier, Martinovich and Mahoney (2006) and Kim et al. (2006) independently re-
analysed the data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP) and found contradictory results. While Elkin et al. (2006) reported no significant therapist effects; Kim et al. (2006) found that between 5%-10% of the variance in client outcome was attributable to individual therapists. These studies are particularly significant for the field because they not only used the same large RCT dataset- they also used overlapping measures of therapy outcome, such as the Beck Depression Index (Beck, Rush, Shaw & Emery, 1979), as key variables. Therefore, the studies excluded sample variations and measurement issues as contributing to outcome differences and in turn, highlighted the role of different approaches to the analysis as the causal factor in the divergent findings (Soldz, 2006).

Soldz (2006) argued for example that a failure to find consistent results was due to the choice of models used and the way data was organised during the statistical analyses (Soldz, 2006). For example, Kim et al. (2006) used a simple pre- post test model using patient’s available termination scores as outcome measures. In contrast however, Elkin et al. (2006) used a complex linear curve model or linear rate of change to assess outcome. Thus, different definitions of outcome were used which were not directly comparable. Furthermore, in line with traditional research developments, Kim et al. (2006) included pre-test or baseline scores as a covariate, while Elkin et al. (2006) adopted an anchored approach. Thus by design, the linear curve model increased patient variability and hence, decreased therapist effects (Wampold and Bolt, 2006).

Additional methodological issues such as the inclusion of therapists as a fixed or random factor within models; a failure to include all levels of data: client, therapist and therapy; and the use of outcome measures completed by therapists rather than clients, have also been
shown to be of importance in outcome research (e.g. Kim et al. 2006). For example, if the therapists are treated as a fixed factor, an increase in power to find treatment effects and not therapist effects emerges and in turn, makes treatment effects the main focus of investigation (Siemer and Joormann, 2003). Additionally, such ‘fixed factor’ techniques render the results as only applicable to the therapists under investigation and thus, not representative of the wider therapist’s population. Conversely, the use of therapist-rated measures confounds rater biases with therapist effects and therefore the outcome scores become unrepresentative of actual therapeutic change and hence are deemed inappropriate (Elkin, et al. 2006). These limitations are unhelpful for the development of understanding the true nature and impact of therapist effects upon psychological therapy outcome and arguably need to be carefully considered in all future research (see e.g. Crits-Christoph and Mintz, 1991). Taken together, these findings suggest the need to think carefully about and justify what data is to be analysed, how it is to be analysed and overall, that the chosen model is appropriate with no unreasonable assumptions that cannot be met (Wampold and Bolt, 2006).

In summary, many of the studies within the literature base have only been able to partly meet the above criteria, with variations in statistical procedures being the most prominent deviation due to sample sizes and statistical power issues. This is because multi-level models typically require large data sets (e.g. Hoelter, 1983) and yet many published studies on therapeutic outcome have much smaller sample sizes. For this reason, even recent studies for example, Vocisano, Klein, Arnow, et al. (2004) and Huppert, Bufka, Barlow, et al. (2001) have used analysis of variance (ANOVA) and/or analysis of covariance (ANCOVA) as alternative statistical procedures.
In this study, it was not possible to use multilevel modelling techniques due to the smaller sample size and thus low statistical power (e.g. Hoelter, 1983). Consistent with the literature base, ANCOVA’s were chosen as an alternative method of enquiry. Further to this and in line with Kim et al. (2006), the data sets used in the analyses were obtained from a questionnaire measure that was completed by clients. Additionally, a basic pre and post score design was utilised, with pre test or baseline scores incorporated as a covariate.

**Factors contributing to mixed findings between studies: study design**

Predominantly, the evidence for the importance of individual therapist characteristics has come from randomised control trials (RCT’s). Although acknowledged as the ‘gold standard design’ to investigate therapy effects, their strict and rigorous training, implementation, and supervisory processes are intended to ‘eliminate’ therapist effects and maximise the power of the treatments (e.g. Zwarenstein, Treweek, Gagnier, Altman, Tunis, et al., 2008), which means that they do not adequately allow for the exploration of the unique contributions of therapist characteristics. For this reason, to further progress this line of inquiry, more research in naturalistic or ‘real world therapy settings’ are urgently needed. Data arising from regular treatment settings allows a specific focus on therapist effects without the restraints that are customary within RCT’s, and therefore provides an opportunity to both identify and understand realistic effect sizes within the ‘real world’ of psychotherapy. Thus, ‘real world’ effect sizes (i.e. the impact of therapist training and experience) would be expected to be higher due to the less rigid or extensively provided processes such as supervision. However, naturalistic studies encompassing such statistical techniques are relatively rare. Of the few studies completed, Okiishi, Lambert, Nielsen, and Ogles (2003) found significant variability between therapists for the outcomes of 1,841 students that
completed therapy at a university counselling centre. The percentage of variance accounted for by individual therapists was not reported. However, both a ‘supershrink’ and ‘pseudoshrink’ were identified. This study thus gives additional support to the importance of identifying what factors influence such therapist effects.

Another large study of therapist effects in a naturalistic setting was completed by the Project Match Research Group on treatments for alcohol misuse (Project Match Research Group, 1998). Encompassing a sample of 54 therapists with a minimum of ten clients each, significant differences among therapists were identified in relation to both client satisfaction and outcome. It was reported that such effects were due to an outlier therapist, although the identified outlier was a different therapists across different analyses. Thus these results also evidence the role of differential therapist effects or ‘therapist and client’ interactions (Project Match Research Group, 1998). In a more recent study, Wampold & Brown (2005) investigated a large administrative database of clients who received therapy from a national care organisation and, who completed psychometric measures pre and post therapy. They reported therapist effects of between 5-8%, similar in range to Kim et al. (2006).

A more recent study in the area, Lutz, Leon, Martinovich, Lyons & Stiles (2007), utilised a naturalistic data set with over a thousand patients and 60 therapists to assess the amount of variance attributable to therapists by using a repeated measures design. Additionally, they incorporated client intake variables and applied a three-level growth curve to encompass three levels of nested data: sessions, patient and therapist. Furthermore, they used a cross-validation procedure, excluding data for ‘outlier’ therapists to gain clarity on the ‘true’ range of therapist variability. The authors reported that approximately 8% of the total outcome variance and 17% of the variance in the improvement of individual clients
was attributable to the therapist. Additionally, these findings were further supported by the cross-validation analyses. These results not only challenge the negative effects of outlier therapists upon outcome variability (or the idea that therapist effects are only due to the unusual very good or very bad therapists) but importantly, suggest the necessity of incorporating client severity scores at intake alongside, therapist characteristics and therapy variables within study designs (Lutz et al., 2007). Empirical support for such suggestions was gained by Saxon and Barkham (2012) during their investigations of the influence of client symptom severity, risk scores and therapists caseloads. Thus on completion, it was shown that the average size of therapist effects was 6.6%. However, it was reported that such effects significantly increased as client symptom severity scores increased and that the greater level of risk within a therapists caseload was associated with poorer outcomes overall. It can be concluded therefore, that incorporating these variables into future studies would enable researchers to identify more robust and realistic effect sizes attributable to therapists (Lutz et al., 2007).

Taken together, these studies clearly indicate that therapist effects also impact upon client outcomes in real world therapy settings; a finding which has considerable clinical significance. However, the research to date has predominantly drawn upon specific client samples and thus, it’s generalizability is questionable. Additionally, with the exception of the study conducted by Saxon and Barkham (2012), every single one of the studies cited so far have been American; this begs questions about the impact of therapist characteristics within a different cultural, social and health setting such as Britain. It is argued therefore that further research is needed and specifically within a naturalistic and varied British clinical populations.
In summary, despite the restrictions and limitations of the existing research base, what can be concluded is that there is evidence that therapist effects play a significant role in therapeutic outcome. Over and above this conclusion however, as yet not much is known about the specific variables that underpin these effects (e.g. Beutler, 2004).

**Understanding the contribution of specific therapist effects**

Until now this argument has treated the construct of ‘therapist effects’ globally, as the sum total of all the individual aspects of a therapist which might impact client outcome. This has been done because it is at this, arguably crude level, that the literature reviewed so far has treated the variable. However as reviewed in the section on theoretical models of therapist competence, training and supervision, ‘the good therapist’ is not one variable but constitutes a complex array of multiple variables. With growing recognition of such complexities, researchers have begun to investigate specific therapist characteristics and their contribution to psychotherapy outcome.

**Specific therapist effects: Early research**

Initially, researchers focused their attention upon the influence of ‘observable traits’ or enduring characteristics of the therapist such as sex, age and race (Beutler, 2004). In one meta-analytic review of 58 studies which included therapist sex as a variable for example, Bowman, Scogin, Floyd and McKendree-Smith (2001), found a significant but small effect size favouring female therapists (d=.04). However, no support was found for the matching of client and therapist sex in relation to dropout rates. Conversely, Beutler, Malik, Alimohamed, et al. (2004) reported that of 10 studies only one (Krippner and Hutchinson, 1990) found a significant effect of sex on outcome, also favouring female therapists, and only one (Sue, Fujino, Hu, Takeuchi and Zane, 1991) found a significant effect of client –
therapist gender matching. Therefore, the evidence that female therapists are ‘better’ than male therapists is weak; and there is a lack of evidence that female clients do better with female therapists and male clients with male therapists, a conclusion that equals that of Bowman et al. (2001).

The variable of therapist’s age has often been omitted from studies or undertaken as a post hoc analysis due to the difficulty of teasing this variable apart from other confounding variables such as experience and theoretical orientation (Beutler, 2004) which might equally be thought to impact on client outcome. Nonetheless, some early studies suggested the presence of a modest relationship between therapist age and client outcome (e.g. Morgan, Luborsky, Crits-Christoph, Curtis, and Soloman, 1982; and Luborsky, Mintz, and Auerbach, et al., 1980). For example, Beck (1988) found that of all age matching levels, therapists who were younger by 10 years or more than their clients obtained the poorest outcomes. Similarly, Dembo, Ikle, and Ciarlo (1983) found that young adults between the age of 18 and 30 years experienced less distress and social isolation if their therapist was no more than 10 years older or younger than themselves. Such findings do suggest some role of therapist’s age on psychological therapy outcome. However, in an extensive review, Beutler et al. (2004) concluded that there is ‘little contemporary research to suggest that age or the similarity of patient and therapist age contributes significantly and meaningfully to treatment outcome’ (p.231).

In terms of race, the focus of the research to date has been on the therapeutic dyad, specifically whether therapist-client racial/ethnic matching may improve outcome (Beutler et al., 2004), in particular for non-white clients due to the research evidence of in-therapy experience of racism for BME clients. Early studies (e.g. Atkinson and Schein, 1986; and
Sexton and Whiston, 1991) reported small effects between client-therapist ethnic similarity and therapy outcome. However, it was found that results were often difficult to interpret due to inadequate differentiation between ethnic groups (e.g. Neimeyer and Gonzales, 1983), or because the number of ethnic minority identified therapists was too small to justify analyses (e.g. Proctor and Rosen, 1981). Therefore, it was concluded that small advantages in terms of client outcomes maybe attributable to ethnic matching but such advantages were not consistent across different ethnic groups and thus, no definitive conclusions could be drawn (Beutler et al., 2004).

In summary, despite some promising avenues of investigation, there is little evidence that therapist demographic variables such as sex or age or race impact on the outcome of psychological therapy for clients. Therefore, at the current time, therapist demographic characteristics are viewed as poor predictors of outcome and as a result are rarely investigated as the primary variables of interest (Beutler, et al., 2004).

**Specific therapist effects and the therapeutic relationship**

In contrast, an extremely promising and developing avenue of investigation has explored therapist characteristics that are hypothesized as impacting upon the therapeutic alliance. The quality of the therapeutic relationship from the perspective of the therapist, client, or external observer is an extensively studied predictor of treatment outcome (e.g. Orlinsky et al., 1994; Beutler, Machado, and Neufeldt, 1994) which is considered to play a central role in producing effective therapeutic change (e.g. Horvath and Symonds, 1991). For instance, large meta-analyses have shown moderate effect sizes of the therapeutic alliance and outcome (e.g. Hovarth and Symonds, 1991). Initially, it was assumed that such findings were directional, in that a good relationship was assumed to produce good outcomes. More
recently however, it has been found that the size of the correlation between the
relationship quality and outcome increases over time and regardless of factors such as early
symptom change (Saunders, 2000), which suggests an independent link between the
therapeutic relationship and psychotherapy outcome.

In light of these findings, a range of therapist variables that may contribute to the
therapeutic relationship have been studied. These include but are not limited to: therapists’
personal characteristics (e.g. Dunkle and Friedlander, 1996), theoretical orientation
(Krupnick, Sotsky, Simmens, et al., 1996), and therapist level of training and experience (e.g.
Mallinckrodt and Nelson, 1991). For instance, in an extensive review of more than 2,000
process-outcome studies, Orlinsky, Grawe, and Parks (1994) identified several therapist
variables that have been shown to consistently impact upon therapeutic outcome: therapist
credibility, skill, ability to engage with the client, to focus upon the client’s problems, and
the ability to direct the client’s attention to their affective experiences. The relationship
factors most frequently studied however have been the facilitative or core conditions
proposed by the person-centred school of thought: empathy, positive regard, and
congruence (Rogers, 1957). For example, in a review of 17 well-designed studies Lambert,
DeJulio and Stein (1978) reported modest evidence to support the relationship between
these facilitative conditions and outcome. Additionally, Lafferty, Beutler, and Crago (1991)
investigated the differences between more and less effective therapists based upon the
traditional measure of client self-reported levels of symptom reduction at the end of
therapy. It was found that the less effective therapists showed lower levels of empathic
understanding than their more effective colleagues. Further to this, Miller, Taylor, and West
(1980) conducted a study whereby they investigated the contributions of therapist empathy
within a cognitive-behavioural therapeutic framework. At the 6-8 month follow-up, client ratings of therapist empathy were found to correlate significantly with client outcome \((r = .82)\), thus accounting for 67% of the variance on outcome. These results not only lend support to the importance of therapist’s level of empathic understanding as perceived by the client but also indicate the importance of therapist empathy regardless of the therapist’s theoretical orientation.

**Specific therapist effects: Training and experience**

There is some consensus that therapists contribute in important ways to building good therapeutic alliances, which in turn are associated with good client outcomes. In contrast there is much less consensus about the variables of therapist training and experience. These variables are the two most widely studied, yet controversial, variables to have been investigated (Beutler, 2004). Discussion of the training and experience literature will be undertaken in turn and will begin with looking at reviews before assessing single studies.

**Training: literature reviews**

In an early review of the training literature, Durlak (1979) conducted a within-study analysis encompassing 42 studies which compared the outcomes of paraprofessionals and professionals. Professionals were defined as ‘individuals with a post-baccalaurate or formal clinical training in psychiatry, psychology, psychiatric nursing or social work’ (p.80), and paraprofessionals were defined as any mental health worker who did not hold these credentials. It was found that of the 42 studies, 28 did not support either group, 12 studies favoured paraprofessionals and only two studies supported professionals. Therefore, it was concluded that paraprofessionals can obtain equal or superior outcomes to professional therapists. It has been argued however, that the results of the review were flawed due to
methodological issues such as the validity of some of the studies, the limited use of outcome measures and the use of multiple and unclear definitions of what constitutes a professional (e.g. Nietzel and Fisher, 1981; Hattie, Sharpney and Rogers, 1984). In light of such contentions, Breman and Norton, (1985) used new inclusion criteria and statistical procedures to re-analyse the data from the studies included in the initial review conducted by Durlak (1979). On completion, the researchers also failed to find an overall difference between the two groups. However, the authors reported that professionally trained therapists gained better outcomes in short term therapy and were more effective with older clients.

While these studies suggest that there appears to be only partial support for the role of professional training, two caveats are important. First, it is argued that the scientific rigour of the studies included within the reviews is questionable. For example, the studies involved were not primarily concerned with the effects of training upon outcome and hence, training was not within their central hypotheses and therefore, power to find effects may have been compromised (Stein and Lambert, 1995). This clearly indicates the need for studies that focus directly upon therapist level of training and its effects upon outcome.

Secondly, the studies reviewed have utilised their own and hence, different, definitions of paraprofessionals. The result of the changing definitions is that some studies have been included in some reviews and excluded from others. Of greater importance however, is that changing definitions has in some cases resulted in a complete change of the characterisation of a group of helpers from a professional to paraprofessional status (for an example, see Nietzel and Fisher, 1981). Additionally, in light of the ambiguity about definitions, it is tempting to equate the comparisons of professional and paraprofessional groups as equal to
comparing groups with professional training and with no training. However, more often than not, this is not the case. For example, in a well known study that posited to investigate the differences between the aforementioned groups, Strupp and Hadley (1979) compared the outcome of professionally trained therapists and university lecturers that did not have a therapeutic degree but did have considerable experience with the target population of students. In this study the outcomes for both groups were similar. Yet the lecturers, due to their many years of experience with students, were very familiar with student difficulties, and typically received regular supervision from professional staff. Thus, the assumption that paraprofessionals have no experience or training is undermined (Atkins and Christensen, 2001). This means that the true effect sizes of therapist training upon client outcome are still unknown. This highlights the importance of clearly defining and categorizing the varying levels of training within a given sample of therapists.

Moving beyond the specific focus of professionals and paraprofessional, Stein and Lambert (1984) completed a more selective review of the literature. For example, studies were included if they focused on clinical problems using treatment approaches such as psychodynamic, and client-centred therapy, and behavioural methods, but approaches such as vocational counselling and the reviews of Durlak (1979), and Hattie et al. (1984) were not included. The overall outcomes reported for this study were similar to those of Berman and Norton (1985), in that the therapeutic outcomes of service providers with and without a professional degree were not found to be different. In relation to specific levels of training however, the researchers noted that therapists’ training and experience was often compounded in studies and therefore three further approaches were used to disentangle the relative influence of the variables. First, a variable representing training was developed
with five categories, from no training/paraprofessionals to professionals with three or more year’s post-degree experience. Second, a continuous variable combining the length of degree and post-degree experience in years was created to represent experience. Finally, studies were given an experience difference score whereby the scores of the less experienced group were subtracted from the more experienced group. Within this more structured design, Stein and Lambert (1984) reported that differences in outcomes were more likely to occur when there are large discrepancies in training between the therapists and the treatment involved more complex interventions over and above, for example, simple counselling or behavioural techniques. These results not only provide support for the influence of training upon therapeutic outcome but also highlight the complexities within such relationships. Arguably therefore, future research on therapists’ level of training needs a comprehensive, hierarchical and structured design to statistically capture the true nature and level of importance of this variable.

More recently Stein and Lambert (1995) expanded upon their investigations, reviewing a further 36 studies. In this investigation the researchers, found modest effect sizes favouring professionals when client satisfaction and client outcome measures were assessed at the end of therapy (d= .27) and when pre- post measures were used (d= .30). Studies that only reported therapist measures and/or reported only post therapy scores did not show effects of training. Thus, these results emphasize the importance of using both client self-reported measures and pre-post scores in all future research. In this review, other potential covariates such as sample size, gender proportions within the client samples, length of therapy and type of therapy were not associated with the relationship between therapists’ training and therapeutic outcome. The researchers concluded: ‘It is clear that a modest but
fairly consistent treatment effect size is associated with training level for a number of measures of client improvement’ (p.192). This study thus provides evidence that, further research on the influence of therapists’ training and therapeutic outcome is needed.

**Training: Individual studies not included within reviews**

Overall, the reviews demonstrate that over and above the mixed findings, a relationship between therapists’ training and therapeutic outcome is becoming evident in more recent research. However, this relationship is clearly complex and not easily observable. Further support for these findings has been gained by some more recent individual studies and studies that were not included within the reviews. In relation to general levels of training for example, professionally trained therapists have been found to outperform their non-professionally trained colleagues (Lave, Frank, Schulberg and Kamlet, 1998), and specifically gained more positive outcomes in relation to symptom reduction (Barlow, Burlingame, Harding and Behrman, 1997). Thus, such results offer support for the importance of mental health training when working with populations that experience these problems. Using a more hierarchical approach to training however, Fals-Stewart and Birchler (2002) reported that while bachelor’s and master’s level therapists were equivalent on adherence to a treatment protocol, the master’s therapists showed greater competence and overall obtained better client outcomes, a finding that indicates that it is not only training or no training that may be of significance but also that the level of training may be of importance.

In line with the view that level of training impacts upon outcome, Howard (1999) conducted a study in an outpatients setting that compared therapists with and without specialist training for anxiety disorders. Specialists were determined by having training in cognitive-behavioural therapy and specialist training with anxiety disorders. Therapists lacking one or
both of these credentials were deemed non-specialist, although all non-specialist therapists were seen as competent to treat anxiety disorders and regularly worked with this specific client group. A total of 20 specialist and 27 non-specialist therapists worked with 86 and 79 clients respectively over a two year period. The results showed that the specialist therapists completed treatment significantly faster than their non-specialist colleagues. Furthermore, clients treated by the specialist therapists had significantly lower rates of relapse over a two year period following therapy. Similarly, Strosahl, Hayes, Bergan, and Romano (1998) examined the effects of a training program for acceptance and commitment therapy (ACT) using client self-report outcome measures within both the pre-training and post-training phases. Eight therapists attended a workshop and engaged in monthly consultation meetings, while ten therapists did not receive training and continued with ‘therapy as usual’. A total of 321 clients, with a range of diagnostic presentation, participated in the study. The ACT therapists saw 61 clients at baseline and 57 clients after training, and the control therapists saw 111 and 92 clients, in the baseline and post-training phase respectively. In line with the findings from the Howard (1999) study, after training the ACT therapists completed therapy more quickly than the therapists within the control group. Further to this, after training, the ACT therapists were found to have better outcomes than the control therapists, as measured by client self-reported coping. Therefore, collectively, these results further indicate that higher levels of training positively impacts upon both the efficiency and effectiveness of therapy outcomes. Furthermore, given the use of baseline measures and a control group within the Strosahl et al. (1998) study, a more direct relationship between training and outcome is being established.
Interestingly, one of the most thorough studies to highlight the complex nature of the relationship between training and outcome was conducted in the early 1980’s and not included in any reviews. Thompson, Gallagher, Nies and Epstein (1983) examined the differences between professionals and paraprofessionals conducting group therapy for depression in the elderly following an 8 week training program on behavioural interventions for depression (Lewinsohn, Munoz, Youngren, and Zeiss, 1978). The study encompassed 16 professionals and 16 paraprofessionals. The professionals were employed as mental health therapists and their education ranged from a baccalaureate degree to doctoral degrees. The paraprofessionals were not therapists but were involved with the general care of the clients.

All staff involved completed questionnaires before and after training to assess their knowledge of behaviour theory, problem-solving skills and attitudes towards the elderly population. On completion of the training, both groups of staff were placed into pairs (either professional or paraprofessional) and led a group intervention for approximately 6 to 8 clients. The elderly clients (N=96) completed a battery of questionnaires to assess depression, pleasant and unpleasant activities and general life satisfaction before and after their participation in the group and also at two months follow-up. Each of the group interventions was recorded to rate the effectiveness of each member of staff as a group leader, alongside their levels of non-specific skills such as warmth, empathy and genuineness.

The results showed that the training enhanced both the professionals and paraprofessionals knowledge of theory and therapy. However, the professionals demonstrated a greater level of knowledge at both baseline and following training. There were no differences between the groups in relation to problem-solving skills and attitudes towards the elderly.
Simultaneously, both groups scored equally on levels of effectiveness, competence and the identified non-specific factors. However, a non-significant trend that paraprofessionals exhibited greater levels of warmth and empathy was identified. The client ratings showed that all participants had experienced significant reductions in their levels of symptomology and increases in their frequency of pleasant events and overall life satisfaction. In other words no overall differences in terms of client outcomes were found between the groups led by professionals and paraprofessionals. However, the participants in the professional-led groups reported greater increases in life satisfaction by the end of therapy. Further to this, no overall differences were found between participants of either group at follow-up, although participants from the professional led group reported significantly higher scores on two subscales of the life satisfaction measure: social contact and satisfaction with life in general. Additionally, participants in the professional-led groups reported significantly higher levels of satisfaction with their therapy overall, also rating their overall improvement as higher and rating the quality and helpfulness of some of the components of therapy higher than participants in the paraprofessional-led groups. Finally, a non-significant trend that participants in the professional-led groups found their therapy more helpful overall was reported (Thompson et al., 1983).

This study is clearly important in relation to methodological considerations and the developing understanding of the impact of training upon outcome. On a methodological level, the study employed both global and specific measures of outcome. On a global level, differences in effectiveness due to training appear to be difficult to identify. However, on more specific scales, differences are clearly apparent. Thus, both global scores and subscale scores should be considered in all future studies to further enhance current understanding.
of the level and nature of the effects of therapists training upon outcome. On a clinical level, this study, in the first instance, evidently supports the general findings that paraprofessionals can be as equally effective as professional therapists (Durlak, 1979). However this finding was only related to general scores. Therefore, in line with Stein and Lambert (1995), these results indicate not a blanket effect but differential effects as crucial differences between service providers with different levels of training. Interestingly, the results of this study also showed that paraprofessionals were rated more highly on the non-specific factors which suggest that their greater warmth and optimism may be possible mechanisms of therapeutic effectiveness (Strupp and Hadley, 1979). This finding is consistent with the literature on the importance of the ‘core conditions’ (Rogers, 1957) in relation to therapeutic change. Equally however, such personal attributes are ‘necessary but not sufficient’ (Beck et al., 1979). Therefore, arguably, it may be that the level of effectiveness of paraprofessionals may generally parallel that of professionals when clients present with lower levels of symptomology and distress, and the therapeutic intervention required remains at a lower level of complexity. However, if the presenting difficulties and thus the therapy required are more complex, such general outcome similarities between professionals and paraprofessionals may diminish. Therefore, in line with the findings of Stein and Lambert (1984) it is possible that the greater the differences in training between service providers and the greater the complexity of the therapy, the greater the effects of training will be upon client outcome. Thus, more research is needed encompassing a greater range of training levels between therapists, alongside differing levels of client and therapy complexity.
Experience: Literature reviews

Relative to the number of studies investigating the influence of therapists’ training and therapeutic outcome, research on therapist experience and outcome is sparse. Additionally, the definition of ‘experience’ (typically years of clinical practice) and thus investigations into its influence upon outcome appear to have historically been compounded with ‘level of training’ and thus, a general understanding of the influence of experience upon outcome has been problematic. However, it is for these reasons that the influence of therapist’s experience should be independently considered (e.g. Beutler, 1997).

In an early review of the literature, Bergin (1971) examined the findings of 48 general psychotherapy outcome studies. On completion of the review, it was reported that 53% of the sampled studies indicated positive results for more experienced therapists, while only 18% of the studies that used inexperienced therapists showed improvements. This finding suggests a positive relationship between therapist levels of experience and outcome, although such findings appear tentative given the number of studies encompassing less experienced therapists only (e.g. Stein and Lambert, 1984). In a more carefully considered review however, Auerbach and Johnson (1977) examined within-study comparisons of professional trainees and novice clinicians relative to more senior therapists, while omitting all studies of paraprofessionals. They found that more experienced therapists were able to form better therapeutic relationships with clients than novice therapists, and overall produced better outcomes. However, the relationship between therapist experience and outcome was weak at best (Auerbach and Johnson, 1977; Christensen and Jacobson, 1994).

Using a between-studies design, Smith and Glass (1977) correlated years of experience with standardised outcome measures from 475 studies that investigated the general
effectiveness of therapy. Interestingly, their coding of therapists experience was based upon an estimated number of years of professional training. Thus, a major criticism of this study is that the authors muddled the training and experience variables. Nonetheless, individuals with less than a Masters degree were coded ‘0’, Masters level individuals were coded ‘3’, and individual that had gained a recognised Doctoral degree were given the largest code of ‘5’. In line with Bergin (1971), many of the studies included in the review encompassed relatively inexperienced therapists with only an estimated 30% gaining a total of five years experience inclusive of their training. Contrary to Bergin (1971) however, Smith and Glass (1977) did not find a relationship between years of experience and therapy outcome (r=.00). However, further investigations of a restricted number of studies that included psychotic clients that had received non-behavioural interventions revealed an effect size of .17 (n=180). The researchers therefore concluded that the identified relationship was ‘tiny, but not bad considering how much unreliability there was in our estimates of therapists experience (1980, p223)’.

As part of a large scale meta-analysis investigating the efficacy of different treatment approaches, Shapiro and Shapiro (1982) also correlated estimates of therapist years of experience with treatment effects across 145 outcome studies. In this research, therapist experience was coded in years, whereby undergraduates gained a score of ‘0’, post graduate trainees gained a score of ‘2’ unless the stage of training was specified, and doctoral level therapists were coded ‘5’ unless length of subsequent experience could be inferred (1982, p.584). The length of therapist experience ranged from 0 to 8 years. Thus, the average length of therapist experience was less than in the aforementioned review by Smith and Glass (1977) with a mean of 2.91 years of experience plus training. It was found
that therapist experience, ranging from 0 to 8 years, was negatively correlated with effect size (r = -0.14, p < .01), suggesting a downward trend in effect size with increasing experience from 1 year to 4 years. However this trend was somewhat reversed for the more experienced therapists, although their outcomes remained inferior to those obtained by more novice therapists. Additional analyses however, revealed that this effect was due to studies involving less experienced therapists working with target problems that generally yield better outcomes and thus higher effect sizes. Thus, considered alone, therapist experience accounted for 2% of the variance and lower experience was better. However, when client target problems were controlled for, experience no longer predicted effect size (R change = .0007, F(1)), indicating no overall relationship between therapist experience and outcome. Nonetheless, the researchers concluded that ‘contemporary research is not representative of clinical practice’ (1982, p.598) which suggested that they themselves were dubious about this finding.

Overall, it appears that the aforementioned reviews that have examined the experience-outcome relationship have yielded mixed or negative results. However, such results could be challenged on the basis that many of the involved studies only used a relatively restricted range of inexperienced therapists. Additionally, it is not clear whether the experienced and less-experienced therapists across studies worked with comparable clients and in similar treatment settings (Stein and Lambert, 1984). Instead it seems as if in some instances, more experienced therapists worked with more complex clients and presenting issues which were, in turn, less likely to show treatment improvements. Thus, it could be argued that client factors in this research may have obscured the effects of therapist experience. Therefore, the effects of therapist experience on outcome remain unknown and thus, more
studies encompassing a greater range of therapist experience, undertaken within ‘real world’ clinical settings are urgently needed.

**Experience: Individual studies not included within reviews**

On an individual study basis, findings generally give greater support to the role of therapist experience upon outcome, although they do so to varying degrees. For example, it has been shown that regardless of professional discipline, more experienced therapists gain a greater number of positive outcomes than less experienced therapists (Propst, Paris and Rosberger, 1994) and specifically produce more effective outcomes with a range of presenting problems, while less experienced therapists were only effective with certain types of clients (Luborsky et al., 1997). These studies suggest that level of experience influences both the effectiveness and diverse flexibility of therapists. Similarly, in a re-analysis of the Multi-Centre Collaborative Study for the Treatment of Panic Disorder, Hupert, Bufka et al. (2001) investigated therapists’ level of experience alongside their levels of training and found that experience was significantly associated with reductions in client symptomology (r=.72). However, they did not find that the amount of time therapists had spent conducting therapy was more important than therapists’ more general clinical contact (r=.20). This study is interesting because it is one of the few that attempts to ‘unpack’ what therapist ‘experience’ might mean, suggesting somewhat counter-intuitively that hours spent actually doing therapy may not be the critical aspect of ‘experience.’

More recently, Franklin, Abramowitz, Furr, Kalsy, and Riggs (2003) explored the relationship between therapist experience and outcome within a large-scale effectiveness study within the context of an adult OCD clinic. A total of 11 doctoral level clinical psychologists and 16 clinical psychology interns participated. Therapist level of experience ranged from no post-
doctoral experience to 17 years post-doctoral experience. Client participants were 86 self-referred outpatients and were deemed by the researchers ‘typically more complex’ than individuals within RTC’s and thus, arguably this study is more representative than some of the others reviewed of individuals receiving treatment within the community. Clients received the same treatment but in one of three treatment groups, with each group being identified by the therapist level of experience: therapists with less than one year experience (client N=20), therapists with 2-8 years experience (client N=42), and those with 9 or more years experience (client N=24). Client outcomes were measured by a semi-structured interview, inclusive of a severity rating scale for obsessions and compulsions, and a depressive symptom scale. The results showed a significant group x time interaction indicating that a) clients treated by the more experienced therapists had higher pre-treatment OCD severity scores and b) there were no group differences in OCD severity scores at post-treatment. These findings suggest that the clients treated by the more experienced therapists made the most progress overall and thus, the results of this study, clearly supports the role of therapist experience upon outcome. This is an important finding because unlike previous investigations, a naturalistic design was used and the clients receiving treatment were more representative of individuals treated in the community. Thus, the findings may be a more true representation of the effects of experience upon outcome within general practice.

**Training and experience: A collective study**

It has been argued that the variables of training and experience while separate have been crossed in a number of the studies to date. In this context it is useful to examine the findings of studies which have attempted to investigate both variables. Of particular significance for
the current research, Burlingame, Fuhriman, Paul, and Ogles (1989) investigated the relationship of both therapist training and experience on outcome in time-limited therapy at a university counselling centre. The study involved 6 trainee therapists and 6 senior staff, encompassing clinical and counselling psychologists and senior social workers. The level of experience for therapists in training ranged from 1 to 5 years (mean=2.5), while the senior staff ranged in experience from 4 to 15 years (mean=9.2 years). The age range of therapists was 25 to 31 years (trainees) and 40-55 years, (senior staff). Their theoretical orientations were identified as cognitive-behavioural (3), dynamic (2), humanistic (3), and eclectic (4). The client group consisted of 57 (26 male and 31 females) walk-in clients that did not meet a predetermined exclusion criterion: severely depressed, psychotic, borderline personality, primary difficulties with anger, poor self identity, and unrealistic expectations of therapy. Instead, individuals were included in the study based on their ability to form a therapeutic relationship, if they had a minimum of one successful past relationship, had a clearly defined problem, and a good pre-morbid history. During the study, the 12 therapists were matched on experience and randomly assigned to one of three training groups: no training (NT), self-instructed training (ST), and intensive training (IT). On completion of the training phase, each therapist, regardless of training condition, were instructed to conduct therapy in their preferred theoretical orientation (Fuhriman et al., 1986), although the therapists of the ST and IT groups were encouraged to follow the phases of their training. All sessions were recorded and both clients and therapists completed a battery of questionnaires before and after therapy, and at 6 months follow-up.

Following a series of ANCOVA’s, regressions and chi square analyses, main effects for therapist experience on all outcome measures, was reported, indicating that clients seen by
more experienced therapists made greater improvements. Additionally, more experienced therapists reported greater improvements in their clients than their less experienced colleagues. However, when examined for clinically significant change (as opposed to statistically significant change), no differences were found between the more and less experienced therapists. Nonetheless, on an individual basis, of the 8 clients that demonstrated clinically significant change, 6 had been treated by more experienced therapists, which in turn, parallel the main effects. In relation to therapists’ training, no significant main effects were found. Nonetheless, consistent trends were in the expected direction since clients treated by more intensely trained therapists showed more improvement at the end of therapy and at follow-up. However, there were no interaction effects between the two variables (Burlingame et al., 1989). These results demonstrate an effect of therapist experience on outcome and further support a positive relationship between level of training and outcome. However, methodological weaknesses do impact the credibility of the results: the study was undertaken at a single setting, inconsistent results across outcome measures and the small sample size, potentially limits the generalisations that can be made. Therefore, it is proposed that investigating training and experience, simultaneously, within a real world setting and encompassing a larger number of participants would undoubtedly add to the current understanding of the influence of these variables upon outcome.

Summary

Overall, it appears that research into the effects of the therapist characteristics of training and experience remains inconclusive. As summarized above there are tantalizing clues that the type and level of training as well as the amount of experience that a therapist might
have are likely to be important factors in how clients do in therapy, however this has not yet been clearly evidenced. Given the fact that therapeutic trainings represent a significant investment both monetarily and in terms of time/energy, that accreditation bodies (e.g. BPS, BACP, UKCP, HCPC) set training standards, there is a clear assumption in the profession that training is important. In addition, the value of experience is equally assumed, e.g. being correlated typically with higher salaries or more senior positions. In this context it thus seems surprising that research in this area has declined (Beutler, Machado, and Neufeldt, 1994). It appears that this decline, in part, is attributable to increasing attention towards investigating the efficacy of different treatments, in addition to the methodological problems inherent within this area of research (e.g. Beutler, 2004). For example, research has been particularly hampered by the difficulty with and inconsistency in terms of training and experience which has made the interpretation of results problematic (e.g. Bowman, et al., 2001). It is argued however, that such a decline in this area of study is premature and more research is desperately needed (Beutler, 1997).

To overcome some of the historical aforementioned difficulties, it is suggested that a number of issues need to be carefully considered to differentiate training and experience in an attempt to untangle and understand these variables. For example, ‘training’ has commonly been vaguely defined and often presented in terms of academic degrees. Therefore, future studies would potentially benefit from clear definitions of training, involving not only levels and length of training but also of academic and therapeutic learning (Beutler, 1997). Equally, equating the independent variable of experience with years in the profession or time passed since gaining a professional role is not a very robust or convincing definition of the variable. Instead it is suggested that all experientially relevant activities
such as providing and/or receiving supervision, general clinical experience, and total number of client contact hours undertaken during the time frame investigated are identified and included in analyses. Moreover, specific care must be taken to ensure that such activities are relevant to the client population under investigation. For instance, if an investigation is undertaken within mental health services, time served and roles conducted in other services, for example, working with a learning difficulties population, should not be included in the data collection (Beutler, 1997). Furthermore, it may also be important to consider the inter-relation of therapist experience with client and therapy variables. For example, the effects of therapist experience have been shown to vary in a non-linear manner due to variance in client factors and therapeutic factors such as level of initial distress and number of sessions (e.g. Stein and Lambert, 1995). Thus, further investigations of therapist’s training and level of experience should include client and therapy data such as initial problem severity and treatment length.

In summary, this literature review has argued that it is important to explore the impact of therapist characteristics on client outcome in the context of a British, NHS naturalistic setting and that is additionally important to deconstruct the variable of ‘therapist characteristics’ and to carefully look at in particular the impact of therapist training and experience upon outcome.

**Measuring therapeutic outcome and the decision to use the CORE**

The issue of measurement is of central importance in the undertaking, understanding and interpretation of outcome research. A variety of methods, measures, and sampling domains, for example cognitive or global distress, are often used and this, makes comparisons
between studies and generalisation of the findings difficult (e.g. Elkin, 1994). Of the various methods available, the most common are rating scales or questionnaire measures.

**Questionnaire measures:**

Many self-report measures have been developed and many of these have only been used once (Beutler and Crago, 1983), which creates difficulties for generalising research findings. For the current study therefore the aim was to select a well-established instrument. The next decision was the type of instrument.

Dimensional measures are ‘paper and pencil’ questionnaires that can be completed by different informants such as clinician and/or clients. Typically, the concordance rates between clinician and client ratings are often low during the acute phases of distress but generally improve at the end of treatment and at follow-up (Parker, Roussos, Hadzi-Paviović, et al., 1997), which supports the use of such techniques as outcome measures. Primarily however, the most widely used instruments in research are client self-report instruments. Typically these use continuous, multi-item scales which measure the degree of symptom severity and allow a more sensitive approach to subtle changes and in turn, overall treatment response. In addition self-report measures are quick to use and do not only aid the ease of administration, interpretation and data collection but also enable the collection of data from a larger number of participants. Additionally, training requirements are minimal which makes them time and cost effective (e.g. Lambert, 1999).

Self-report measures ‘tap’ different domains of functioning. For example, the Beck Depression Inventory (BDI: Beck, Ward, Mendelson, et al., 1961) assesses predominantly the cognitive elements of depression, whereby the Hamilton Rating Scale for Depression (HRSD:
ref) focuses more on biological symptoms. Thus, both instruments produce one-dimensional 
 scores of symptomatic change. Arguably, such a narrow focus of investigation can be 
 problematic on two accounts. First, some instruments may measure domains that are more 
 readily compatible with certain types of therapy and may indicate a greater degree of 
 success than other measures. For example, given that the BDI assesses the cognitive aspects 
 of depression, greater rates of change may be identified within cognitively based therapies 
 than within other therapeutic styles (Weisz, Donenberg, Han and Weiss, 1995a). Secondly, 
 symptomatic change coincides with changes in underlying cognitive or emotional 
 mechanisms, and equally takes place within a wider relational and social context (e.g. Kazdin 
 and Kendall, 1998). Thus, improved well being is not merely the absence or reduction of 
 symptoms but encompasses positive change, within multiple domains and in turn, the 
 measurement of different areas of functioning should be employed (e.g. Kazdin, 1994a).

To obtain a holistic approach to outcome, the use of multiple, individual measures might be 
 considered but could be time and effort costly for clients. Instead for the current study it 
 was decided to use a robust global measure of change (e.g. Roth and Fonagy, 2005). 
 Generally, there is little consensus as to which global measure should be utilised and a range 
 of instruments have been employed which consequently, has led to further difficulty in the 
 interpretation and comparisons of research findings. As a result, researchers are 
 increasingly utilising ‘benchmarking or service profiling’ multi-dimensional outcome 
 batteries such as the Outcome Questionnaire (OQ: Lambert, Finch and Maruish, 1999), and 
 the Clinical Outcomes Routine Evaluation scale (CORE: CORE Systems Group, 1998), in the 
 USA and UK respectively. Arguably, such measures not only exhibit the strengths of 
 individual measures, such as being easy to administer and interpret, but they are also
compatible with commonly used individual measures such as the BDI. Additionally, they can operate as a multi-level assessment package allowing individual level, service evaluation and between service comparisons of effectiveness (Barkham et al., 1998), as well as greater consistency in the measurement of outcome and unmistakable comparisons of the research findings. For these reasons in the current study it was decided to use the global measure of change the CORE. The instrument is further described in the methodology section. 

**Aim of study**

The aim of the study was to use analysis of covariance (ANCOVA’s) to assess the amount of client outcome variance attributable to two characteristics of therapists practicing therapy in a ‘real world’ NHS setting: 1) training and 2) experience.

**Research questions**

In the study sample:

1) Do some therapists gain better outcomes than others?

2) Is therapist level of training statistically significantly related to client outcome?

3) Is therapist experience statistically significantly related to client outcome?
Methodology

Design

The study was retrospective in nature and was based on existing archival data from an NHS setting. This data was collected between 2007 and 2012. A between subjects design was utilised.

NHS Setting: Psychological Therapies

Over the period of data collection, the Psychological therapies department was situated within Tier two of the National Health Service Framework. Therefore, it will be discussed within this context and not in its current service delivery, in which primary and secondary services are undertaken separately, with distinct service structures, policies and procedures, as developed in line with the new Mental Health Measure for Wales (2010).

At the time of data collection, the service was based within Abertawe Bro Morgannwg University Local Health Board (ABMLHB). The service was not a ‘walk in’ service but accepted both primary and secondary care referrals from a range of health care professionals such as general practitioners, occupational therapists and psychiatrists. The referrals often encompassed a range of presenting difficulties, such as anxiety, depression, psychosis and personality disorders. Such difficulties often presented with various levels of complexity, and co-morbidity or the simultaneous presentation of two or more mental health problems as identified within the DSM IV (APA, 2000), was common. However, individuals with identified cognitive degenerative disorders such as dementia or with a diagnosed learning disability were directed to more specialist services, which was in line with a needs- led approach to care (e.g. Equalities Bill, 2010).
In line with service requirements at the time of data collection, the service users were men and women all aged between 18 and 65 years. The individuals that presented to the service were from a range of cultural, religious, and socio-economical backgrounds, with varying levels of educational achievements. However, it is important to note that only a small percentage of individuals that presented to the service were from more racially or ethnically diverse backgrounds or minority groups. Thus, individuals were predominantly white and of British origin. Previous psychological engagement varied between service users, from no therapy to an extensive number of interventions.

A total of twenty one staff (nineteen women and two men) worked within the department during the data collection period: one psychiatrist; seven nurse therapists; two therapists; three trainee therapists; three psychologists; one trainee psychologist; and four assistant psychologists. The staff included the author, who is a trainee psychologist. The staff had a wide range of practice experience from newly appointed to many years service post qualification. Their theoretical orientations consisted of psychodynamic (4), cognitive-behavioural (11), eclectic (1), and integrative approaches (5). Additionally, many members of staff had completed further ‘specialist’ training including psychosis, personality disorders, eating disorders, and grief work.

In the service at this time, a referral was deemed ‘service appropriate’ by two suitably qualified members of staff, and the individual concerned was contacted in writing, with an attached ‘opt-in’ slip to be completed and returned if they still wished to engage in therapy. Upon the receipt of an ‘opt-in’ request, individuals were offered an appointment for an initial assessment. During the assessment process, each individual was asked to complete, at minimum, the Clinical Outcomes in Routine Evaluation (CORE: CORE Systems Group,
1998), in addition to other questionnaire measures such as the Becks Depression Inventory (BDI; Beck and Steer, 1987) if applicable, alongside agreeing with the assessor a suitable therapeutic intervention or package of interventions to meet their individual needs. On completion of the assessment, individuals were placed on a waiting list until their turn was reached. Individuals were then allocated to an appropriately trained member of staff, (in line with the previously agreed intervention plan) when a space became available on their caseload. For example, guided self help interventions were allocated to assistant psychologists, telephone CBT was completed by CBT therapists, and more complex cases were undertaken by the remaining members of staff. Thus, full randomisation in terms of client allocation to therapist was not achieved, but a stratified matching system was utilised whereby clients were allocated dependent upon problem and intervention type (note that the current study however, is based only on face-to-face therapy and excludes self-help and telephone interventions). The clients in each sub-group were then randomly allocated to therapists. At the start and end of therapy, individuals were again asked to complete the CORE and any other additional measures they initially completed during the assessment process.

During the period of data collection, the service provided both individual and group interventions in various therapeutic orientations. The individual interventions, such as guided self-help and telephone CBT, in addition to the group therapies, were time restricted. For more complex one-to-one interventions however, the service was not ‘time restrictive’ but operated within a ‘time sensitive’ philosophy. Therefore, therapeutic contracting was undertaken on an individual needs basis, which in turn resulted in a diverse range of the number of contracted sessions. For example, the needs of one individual may
have resulted in a short term contract of six sessions, whereby, for another individual an initial open contract with regular reviews may have been proposed and an ending agreed during therapy dependent upon therapeutic change. A maximum number of sessions was based upon professional judgement and not specified by the service.

Arguably therefore, the psychological therapies department, historically, presents as an ideal ‘real world’ setting in which to answer the proposed research questions. In contrast to RCT’s, ABMLHB offered a greater range of client difficulties with various levels of severity; more varied and complex treatments; and therapists with more diverse levels of training and experience. This is important because the existing literature provides hints that the greater the discrepancies within the client, therapy and therapist variables, the greater the likelihood of capturing the nature and level of importance of therapists effects upon outcome (e.g. Stein and Lambert, 1984).

**Participants**

**Clients:** A total of two hundred and fifty five client questionnaires dated between 2007 and 2012 were located in the service archives. Many of the questionnaires had missing information and were excluded from the sample. A total of 109 (est. 42.75%) completed pre and post therapy data sets were identified for analysis (see section on identification of sample below for further information): this completion rate, although appearing relatively low, is above the 39% average completion rates found across a range of services (Bewick, Trusler, Mullin, et al., 2006). The sample consisted of 37 (33.9%) men and 69 (63.3%) women. The average age of the group was 43.96 years, ranging between 18 to 72 years. No additional demographic data was available. In line with service inclusion criteria, all would have been diagnosed with a minimum of one Axis I disorder with some likely to have
encompassed an additional Axis II diagnosis or clinically relevant Axis II traits or features. As assessed by CORE and as seen in Figure 1 below, the participants’ level of distress at the start of therapy ranged between 9 and 117, with a mean score of 75.06, with the mean score placing the sample within the moderate to severe level of distress in relation to the wider British population (CORE Systems Group, 1998). The individual’s scoring below the clinical cut off point however, were excluded from the analysis in the first stage, leaving a final N of 104. As seen in Figure 2, the total number of therapy sessions completed by clients ranged between 2 and 65, with clients having an average of 18.96 sessions. The average number of sessions completed in this study appears high in comparison to a mean of 5.9 (SD 3.0) in the UK national data for primary care services. However, in such comparisons, it must be acknowledged that this data is provided from primary care studies and primary care settings commonly implement treatment lengths of six sessions or less (e.g. Morrison, 2004), which in turn, may not be representative of the current sample as it encompasses both primary and secondary care clients.
**Figure 1** Clients' level of distress at the start of therapy

**Figure 2** The number of therapy sessions completed by clients
Practitioners: Of the twenty one members of staff working in the department, a total of 9 (42.9%) were identified as having sufficient client data to be included in the analyses: complete pre and post data sets for a minimum of 5 clients. The 9 clinicians consisted of 4 nurse therapists, 1 trainee therapist, 2 psychologists, 1 trainee psychologist, and 1 assistant psychologist. Four of the therapists disclosed their therapeutic orientation to be cognitive – behavioural, and the remaining described themselves as integrative. The therapists were all British white females and ranged in age from 30 to 56 years, with an average age of 43.22 years. The therapist’s level of academic and therapeutic training ranged from diploma to doctoral level qualifications. All therapists participated in regular continued professional development designed to enhance their training. Six therapists were identified as having some form of specialist therapeutic training in addition to their formal training pathways. The level of experience of the staff ranged from 3 to 32 years of professional experience of working with clients (mean=14.78 SD =9.97). The number of hours worked per week was between 15 and 38 (mean= 32.15, SD= 6.79), with hours of therapeutic contact ranging from 10 to 37 hours (mean= 19.86, SD=7.50). All therapists received regular supervision, although this varied between weekly, fortnightly, and monthly contact: the specific reasons for the variation between supervisory contacts was not clear however, a range of issues may have impacted upon this (for example, individual contracting between therapist and supervisor, allocated time due to caseload and perceived level of support required). Seven of the nine therapists provided supervision to other members of staff, and five had completed specific supervisory training.

As stated, in comparison to the overall staff group, only 43% of the therapists had enough complete client data to warrant them eligible to be entered into the study. This resulted in
the inclusion of 57% of the nurse therapists; 50% of the trainee therapists; 67% of the psychologists; 100% of the trainee psychologists; 25% of the assistant psychologists and 0% of the therapists and psychiatrists. As stated, all the therapists were female. Furthermore, the sample consisted of 36% and 100% of the therapists trained within the CBT and integrative orientations respectively. No psychodynamic and eclectic therapists participated. Explicit comparisons between participating staff and non-participating staff in terms of length and level of training and experience and hours worked were not possible due to not having the relevant information for the staff not included in the study.

Participating staff were selected for inclusion on the basis of having sufficient pre and post client data sets. The number of clients per therapist are shown in Figure 3. The overall inclusion rate of 43% might seem low but the sample remained sufficiently diverse and robust to undertake the analyses because it encompassed therapists from a range of professional backgrounds with varying lengths of clinical experience as well as different lengths and levels of training. Thus, the sample provided a representative level of therapist’s variability to specifically explore and identify therapist effects upon outcomes.
Figure 3 The number of clients per therapist

Measures

Clinical Outcomes in Routine Evaluation – CORE OM (CORE-OM: CORE Systems Group, 1998), is a standardised evaluation and outcome measure designed for use within psychological therapies (see Appendix 1). The instrument was used routinely within the department throughout the data collection period. The CORE-OM is not a diagnostic tool but rather a measure of global distress experienced by the individual over the previous week. In line with the recommendations for the use of the instrument, the questionnaire was completed prior to the onset of therapy and at the end of therapy. It consists of 34 items, all answered on a five-point scale ranging from ‘not at all’ to ‘most or all the time’. The measure has four sub-scales: subjective well-being (4 items), commonly experienced problems or symptoms (12 items), life functioning (12 items) and risk to self and others (6 items). Some of the items address low intensity difficulties and some high intensity
problems in order to increase scoring range and sensitivity to change. In addition, 25% of the items are positively framed with reverse scores.

The instrument is problem scored, thus, the higher the score the more problems the individual experiences and the greater their level of distress. The instrument can be interpreted using three scoring formats: total scores, clinical scores and simple scores. This study is using total scores however information is provided about the other scoring systems because these are sometimes used in the literature. The easiest way to convert between these scoring systems is to calculate the total score and then use the CORE conversion chart (Appendix 2). The possible scores for each scoring format, alongside their clinical cut off scores are shown below in Table 1. In terms of reliable change or change that is not attributable to chance or measurement error, this is indicated by a reduction of 17 or more on the total score, or equally 5 points or more on the clinical or simple scores (CORE Systems Group, 1998). Clinically significant change or sufficient improvement to have moved a client to a score more representative of the general population however, is determined when a client’s score drops by 17, 5 or 5, total, clinical and simple scores respectively and/or moves below a severity boundary (CORE System Group, 1998; Jacobson and Truax, 1991).
Table 1 Range of scores and cut off points for the total, clinical and simple scores of the CORE-OM (non clinical range)

<table>
<thead>
<tr>
<th>Band</th>
<th>Total score range = 0-136</th>
<th>Clinical score range = 0.3-40.0</th>
<th>Simple score range = 0-40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>85-136</td>
<td>25.0-40.0</td>
<td>25-40</td>
</tr>
<tr>
<td>Moderately-severe</td>
<td>68-84</td>
<td>20.0-24.7</td>
<td>20-24</td>
</tr>
<tr>
<td>Moderate</td>
<td>51-67</td>
<td>15.0-19.7</td>
<td>15-24</td>
</tr>
<tr>
<td>Mild</td>
<td>34-50</td>
<td>10.0-14.7</td>
<td>10-14</td>
</tr>
<tr>
<td>Low level *</td>
<td>21-33</td>
<td>6.2-9.7</td>
<td>6-9</td>
</tr>
<tr>
<td>Healthy *</td>
<td>0-20</td>
<td>0.3-5.9</td>
<td>0-5</td>
</tr>
</tbody>
</table>

To investigate the psychometric properties of the CORE, Evans, Connell, Barkham, Margison, and McGrath et al. (2002) conducted a large scale study involving data from two main samples: a non-clinical sample and a clinical sample. The non-clinical sample encompassed students from two universities, alongside a convenience sample of staff, students and relatives (n = 1,106). The clinical data came from 23 sites, most of which were based within the NHS (n = 890). The results showed good levels of internal consistency with α of 0.75 and 0.95 respectively for the two samples. These alpha coefficients indicate that each of the 34 items was measuring dimensions of individual differences and each were adding new information. Test-retest stability was also gained, with correlations of 0.87-0.91 (Spearman’s p) within the non-risk domains. The stability of the risk scale was lowest at 0.64, which was reported as ‘unsurprising in view of the small and situational reactive nature of the items’ (Evans et al., 2002, p53). Additionally, convergent validity against a battery of existing measures was also shown to be good, especially against conceptually close measures such as the Beck Depression Inventory (BDI: Beck et al., 1988), and the Symptom Checklist – 90-
Revised (SCL-90-R: Derogatis, 1983). Finally, differences between the non-clinical and clinical samples were found to be ‘large and highly statistically significant on all domains’ (Evans et al., 2002, p00). For instance, on the non-risk items the non-clinical sample gained a mean of 0.88 (sd=0.66), and the clinical sample scored a mean of 2.12 (sd=0.81), and the ‘all item’ mean scores were reported as M=0.76 (0.59) and M=1.86 (0.75), non-clinical and clinical samples respectively.

Also using the data from a mixed clinical and non-clinical sample (n = 535), Connell, Barkham, Stiles, Twigg, Singleton, et al. (2007) reported Cronbach’s coefficient (Cronbach, 1951) as 0.91 in the general population. This study thus provides additional support that the instrument has a high internal consistency and confirms its robust structure. Additionally, following the procedures of Jacobson and Truax (1991) support for the use of the clinical cut-off value of 10 (using the ‘simple’ scoring system, equivalent to a score of 33 on the ‘total’ scoring system) between the clinical and normal population was also gained (Cornell et al., 2007). In conclusion, the evidence suggests that the CORE-OM is a reliable and valid instrument to measure therapeutic outcomes (Evans, Connell, Barkham, et al., 2002).

**Therapists audit questionnaire**

As part of a service evaluation process conducted during the final months of 2012, all members of staff were requested to complete an audit questionnaire (see appendix 3). The questionnaire was developed by the service clinical lead and assistant psychologists. The aim of the audit was to identify existing skills as well as further training and supervisory needs of the staff, in addition to evaluating overall service delivery. The questionnaire consisted of seven broad sub-sections: Relevant personal information; contract details; academic and therapeutic training; CPD; supervision; caseload information; and general
clinical issues. Questions included: “What is your main theoretical orientation?”; “Please provide information on formal training inclusive of name of course, level, duration and year of completion”; “Please provide current caseload information inclusive of intervention type, total number of clients, and number of sessions to date”; “If you routinely use outcome measures please specify which”. The questionnaire consisted of a total of 36 questions.

Procedure

Overview: The study was retrospective in nature. Therefore, both the client and therapist data had been previously collected as part of the general working and audit procedures within the department and were held within archival records. Approval from the clinical lead of the psychological therapies services was gained. Also, in line with NHS research policies, the Research and Development (R&D) department and ethics board were approached for guidance and approval (see Ethical considerations below). Upon completion of these processes, two verbal requests were put forward to the clinical lead to obtain the client and therapist data respectively. On receipt of the data, client-therapist pairs were identified via their NHS codes and in turn were given new ‘study’ security codes to allow analysis within the research database. This procedure ensured that all stored data was fully anonymized.

Ethical considerations

Research approval processes: The study was approved by the Research Committee at the University of the West of England, Bristol (see Appendix 4). No NHS ethics or Research and Development applications were deemed necessary because the retrospective design and use of unidentifiable data placed the study within the category of ‘service evaluation and
development’ and not within the core domain of research as described within NHS policies (see Appendix 5). Permission for the study to proceed was also gained from the clinical lead of the psychological therapies service within ABMUHB (see Appendix 6).

**Consent:** Written consent was gained from each service user at the time they completed the CORE questionnaires. The consent form stated that anonymized data might be used for audit and research purposes and that they could withdraw any information they provided, at any time, with no further consequences (see Appendix 7).

The therapists completed the audit questionnaire with the knowledge and understanding that the information they provided would be anonymised and used for evaluation and research purposes. In light of this, as a team, all members of staff were verbally informed of the proposed study and were given an opportunity to ask questions and raise any concerns. All members of staff provided verbal consent.

**Confidentiality:** In line with ethical guidelines, access to both the client and therapist archival records was only undertaken by the members of staff that worked with the respective records as part of their day to day role. No client or therapist identifiable information was shared with the researcher or her supervisors. The client and therapist information presented to the researcher was accompanied by an NHS security code which enabled the anonymised client-therapist matching to take place. On completion of the pairing process, new ‘research’ security codes were created for the study.

**Data selection and preparation**

On completion of the ethical approval processes, an initial verbal request for the release of the client outcome data was made to the clinical lead. Upon receipt of the data, a total of
two hundred and fifty five client outcome scores, in addition to demographic data and total number of therapy session scores were released for the study. The process by which the final data set was arrived at is described below but also illustrated in Figure 4 below for clarity.

Figure 4 A flow chart illustrating the selection and preparation process of the data ready for the statistical analyses

Overall, the client information included age, gender, ethnicity and diagnoses. However, the recording of ethnicity and diagnoses was very sporadic across the data set, thus it was decided not to include these variables in the study. Equally, all client records that did not include both pre and post-treatment CORE scores, encompassed missing data, or were not accompanied by a ‘total numbers of sessions’ score were not recorded. The remaining data
sets were then grouped according to their therapist’s NHS security code. Therapists with five or less clients were also excluded. A total of 133 complete client data sets in relation to 14 therapist codes remained.

A second verbal request for the release of the data of the remaining 14 therapists was presented to the clinical lead. However, the information required for the study was only complete for 9 of the identified 14 members of staff. Therefore, only the information in relation to the remaining 9 therapists was considered and, the client information in relation to the excluded therapists was deleted from the database. Prior to entering the therapist information into the database, each therapist NHS security code was replaced with a new research code. Simultaneously, the therapist codes within the client datasets were allocated the new corresponding codes. On completion of the code-pairing process, the therapist information was entered into the database. A total of 109 client datasets in relation to 9 therapists remained for analysis.

**Analysis**

The study aimed to investigate the following questions: What amount of client outcome variability is attributable to therapist effects?; What are the effects of (1) therapist training and (2) experience upon client outcomes?

**Creation of the training and experience variables:** One aim of this research was to provide a more sophisticated operationalization of training and experience than is found in much of the existing literature. However, in the current study there were nine therapists each with data on eight different aspects of training and experience. In order to allow statistical analysis, it was necessary to collapse this data somewhat. Inspection of the data suggested that the most logical approach was to create two therapist groups for each variable.
This process is described in detail and for clarity and ease of understanding training and experience (IV's) will be discussed separately.

**Training:** The original four items were: level of training, years of training, had or had not obtained supervisory training, and had or had not obtained specialist therapeutic training. There were no apparent trends across all of the items in the variable. Therefore, the strongest ‘single item’ trend was sought. The most robust trend in the data was for therapist’s level of academic training (Diploma, undergraduate degree, Masters or Doctoral training). Therefore, the therapists were grouped according to this item. This process identified two groups, consisting of four and five therapists; high and low training groups respectively (see Table 2 and 3 below). It is worth noting that both groups included practitioners that were still in training (i.e. a trainee psychologist in the high training group).

**Table 2** Table showing the therapists training for each of the items that makes up the high and low training groups

<table>
<thead>
<tr>
<th>Level of training</th>
<th>Years of training</th>
<th>Supervision training</th>
<th>Additional specialist training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High training</strong></td>
<td>Post graduate degree</td>
<td>0-6 years</td>
<td>1=yes, 3=no</td>
</tr>
<tr>
<td><strong>(N=4)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low training</strong></td>
<td>Diploma-Degree</td>
<td>0-3 years</td>
<td>2=yes, 3=no</td>
</tr>
<tr>
<td><strong>(N=5)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 3** Table showing the therapists in each training group and the number of client observations for each group

<table>
<thead>
<tr>
<th>Number of therapists</th>
<th>Number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High training</strong></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>48</td>
</tr>
<tr>
<td><strong>Low training</strong></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>61</td>
</tr>
</tbody>
</table>
Experience: The original four items were: years of experience of seeing clients, number of hours worked per week, number of clients seen per day and number of therapy hours provided per week. The most obvious and robust trend in the data was for the therapists total number of years of experience though there were also more tentative trends for number of clients seen per day and therapy hours per week. Therefore, the therapists were grouped according to these trends. This step produced two groups, with 4 therapists in the high experience group and 5 therapists in the low experience group (see Tables 4 and 5 below).

Table 4 Table showing therapists experiences for each of the items that makes up the experience variable

<table>
<thead>
<tr>
<th></th>
<th>Years of experience</th>
<th>Hours worked per week</th>
<th>Number of clients per day</th>
<th>Number of therapy hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>High experience (N=4)</td>
<td>15-33</td>
<td>15-38</td>
<td>4-5</td>
<td>15-30</td>
</tr>
<tr>
<td>Low experience (N=5)</td>
<td>3-8</td>
<td>23-30</td>
<td>3-5</td>
<td>12-23</td>
</tr>
</tbody>
</table>

Table 5 Table showing the number of therapists and clients for the high and low experience groups

<table>
<thead>
<tr>
<th></th>
<th>Number of therapists</th>
<th>Number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>High experience</td>
<td>4</td>
<td>53</td>
</tr>
<tr>
<td>Low experience</td>
<td>5</td>
<td>56</td>
</tr>
</tbody>
</table>
Table 6 Shows which therapists constitutes each of the training and experience groups

<table>
<thead>
<tr>
<th>High training</th>
<th>High experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>2, 8, 7, 1</td>
<td>10, 4, 14, 3</td>
</tr>
<tr>
<td>Low training</td>
<td>Low experience</td>
</tr>
<tr>
<td>10, 4, 9, 14, 3</td>
<td>9, 2, 8, 7, 1</td>
</tr>
</tbody>
</table>

As can be seen in Table 6 above, with the exception of therapist number nine, there was no overlap of therapists in the high or low groups. Thus, the therapists were seen to have high training with low experience or vice versa. This indicates that each group was qualitatively different, however it is also clear that due to the therapist sample in the study, the planned statistical examination of the difference in client outcomes for higher and lower 1) training and 2) experience therapists involved two analyses that, more-or-less, compared the same two groups in each case. This is a limitation of the current sample that is discussed further below.

**Selection of statistical analysis procedure:** Statistical analyses were carried out using SPSS for Windows version 20. As discussed in the literature review, much research in this area utilises multi-level modelling techniques because this is the sole statistical approach that allows for the violation of the assumption of independence of data that is found in nested data (multi level data of multiple therapists, each of whom has their own clients: (e.g. Raudenbush and Bryk, 2002). However, multi-level procedures typically require very large data sets: in an examination of HLM research, Schumacker and Lomax (2010) found that many studies used between 250 and 500 subjects. However, for best estimates at least 50 or preferably 100 therapists are suggested to be necessary (Maas and Hox, 2004), although
Soldz (2006) recommended that at minimum, using 30 therapists each with 30 clients is likely to yield reliable outcomes. Nonetheless, a more liberal rule of thumb for sample size is suggested to be 20 subjects per therapist (Costello and Osborne, 2005). Therefore, to have used HLM in the current study, at minimum, a client sample of 180 would have been required. In counselling and psychotherapy research which has occurred in naturalistic settings however large sizes historically have not been easy to locate. One reason is the tendency in many sites for only a minority of clients to complete post-therapy outcome measures: these low completion rates are due to issues such as unplanned endings, clients reluctance or inability to complete questionnaires, as well as potentially reluctance by therapists to engage in routine outcome monitoring (e.g. Gilbert, Barkham, Richards and Cameron, 2005). As discussed earlier, in the current study extensive mining of the Trust archives for client data collected over a 5-year period still only resulted in a client data set of 109. Therefore, it was necessary to consider an alternative method to use.

The most common methods used to analyse continuous outcome variables are: change – score analysis (CSA), the t-test approach and the analysis of covariance (ANCOVA). Generally, the CSA is undertaken using percentage change; however, this has been shown to be an inefficient method and thus was not considered further (Vickers, 2001). A disadvantage of the t-test approach is that in comparison to the ANCOVA, t-tests require a larger sample size in order to optimise the likelihood of gaining a significant finding (e.g. Borm, Fransen and Lemmens, 2007). Therefore, given the size of the sample in the current study (109), it appears unlikely that t-tests would yield accurate results. Furthermore, it has also been shown that ‘Across a range of correlations between pre-and post-treatment scores and at varying levels and direction of baseline imbalance, ANCOVA remains the
optimum statistical method for the analysis of continuous outcomes in RCT’s, in terms of bias, precision, and statistical power’ (Egbewale, Lewis and Sim, 2014, p49). Therefore, in view of these issues, the analysis of covariance (ANCOVA) appears to be the most appropriate statistical approach to use within the current study.

Additionally, as discussed earlier, many studies within the literature base have also been unable to use HLM techniques. Therefore, many of the well conducted and more recent investigations have also drawn upon ANCOVA’s as an alternative method (e.g. Vocisano et al., 2004; and Huppert et al., 2001). In support of this line of thinking, a series of pre-analysis tests were undertaken to check that the data of the current study met the underlying assumptions of the analysis of covariance. The results of these tests (which can be seen in the first part of the results section) showed that the assumptions were broadly met.

Additionally, statistical guidance was gained from Dr. Paul White from the mathematical department at the University of the West of England (UWE). Therefore, in line with the literature base and with statistical confidence, ANCOVA’s were chosen as the method of enquiry.

For the reasons outlined above, the data was thus examined using analysis of co-variance (ANCOVA’s). The ANCOVA is a parametric statistical procedure that investigates the differences between means but also accounts for an additional variable called the covariate (CV). The covariate is a factor that may correlate with the dependent variable (DV), or which participants may differ on prior to experimental manipulation. Using a covariate means that any differences found between groups are due to just the independent variable (IV) since the ANCOVA adjusts the means of the DV to what they would be if all groups were equal on the CV prior to testing. Thus the ANCOVA potentially provides greater power to find
differences between the means if they are present. In the current study the only covariate was the baseline CORE score. Including this as a covariate ensured that any differences found between clients seen by therapists differing on training and experience was not due to, for example, the possibility that more complex clients were seen by more experienced therapists. Using the pre-therapy CORE scores as the covariate follows recommendations in the literature for analyses focussed on treatment outcomes (e.g. Vickers and Altman, 2001).

In the present study, a number of ANCOVA’s were conducted: the first was conducted on the overall end of therapy CORE scores to examine overall therapist variability. This was followed by an ANCOVA which compared the two training groups in terms of the overall CORE post-therapy score; four further analyses, one for each of the CORE sub scales were also run to investigate the influence of training. These analyses procedure were then repeated for the experience groups. On each occasion, the total or sub-scale (as relevant for the analysis) pre-therapy CORE scores were entered as the covariate. This allowed the means of the DV (overall and sub-scale scores) to be adjusted to what they would potentially be if all clients had equal scores prior to therapy.
Results

In order to answer the research questions a series of analyses were undertaken. The first section consists of exploratory and descriptive statistics, and the second and third sections encompass the results of the analyses for the effects of training and experience respectively. The final segment reports the findings on the interactional effects of training and experience on outcome. In all analyses the total CORE scores were used, where scores over 35 indicated clinically significant distress.

Exploratory and descriptive statistics

Checking ANCOVA assumptions – The pre intervention data was examined by a variety of means before being subjected to any significance testing (Tukey, 1977). This allowed for the data to be tested for any violations of the underlying assumptions of parametric tests and determined the appropriateness of using ANCOVA’s, giving confidence that any findings were not due to error.

The main underlying assumption of parametric tests is that the data is normally distributed (Field, 2006). In order to check the distribution of the overall pre CORE data the histogram in Figure 5 below was initially examined (Field, 2006).
On visual inspection of Figure 5 above, the pre CORE data appears to fall within the normal distribution range. To test this observation statistically however, a Kolmogorov-Smirnov test of normality was conducted. The results of the test indicate that the pre CORE data, $D(104)=0.07, p > .05$ (M=77.8, SD=19.84) is normally distributed and therefore meets the main criteria for parametric testing.

A second Kolmogorov-Smirnov test of normality was also conducted for the overall post-therapy scores (DV). The results of the test indicate that the post-therapy data, $D(104)=0.12, p < .05$ (M=52.03, SD=28.29) is not normally distributed.

The Four pre CORE sub scales scores were also examined for normality. As can be seen in Table 7 below the Problem and Functioning scales are seen to be normally distributed. However, the well-being and risk scale are not normally distributed.
Table 7 The results of the Kolmogorov-Smirnov test of normality for the pre-therapy sub-scale scores

<table>
<thead>
<tr>
<th></th>
<th>Statistic</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well being</td>
<td>.383</td>
<td>104</td>
<td>.000</td>
</tr>
<tr>
<td>Problems</td>
<td>.087</td>
<td>104</td>
<td>.050</td>
</tr>
<tr>
<td>Functioning</td>
<td>.056</td>
<td>104</td>
<td>.200</td>
</tr>
<tr>
<td>Risk</td>
<td>.129</td>
<td>104</td>
<td>.000</td>
</tr>
</tbody>
</table>

The post-therapy sub-scale scores were also tested for normality. Table 8 below shows that the Functioning scale is normally distributed but the well-being, Problem and Risk scales have not met the assumption of normality.

Table 8 Results of the Kolmogorov-Smirnov test of normality for the post-therapy sub-scale scores

<table>
<thead>
<tr>
<th></th>
<th>Statistic</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-being</td>
<td>.092</td>
<td>104</td>
<td>.030</td>
</tr>
<tr>
<td>Problems</td>
<td>.119</td>
<td>104</td>
<td>.001</td>
</tr>
<tr>
<td>Functioning</td>
<td>.081</td>
<td>104</td>
<td>.086</td>
</tr>
<tr>
<td>Risk</td>
<td>.272</td>
<td>104</td>
<td>.000</td>
</tr>
</tbody>
</table>

The other key ANOVA assumption that is also relevant for ANCOVA is Homogeneity of variance. This is checked for both the pre and post-therapy scores using the Levene’s test. The Levene’s test tests the hypothesis that the variance in the groups are equal (thus the difference between the variances is zero). A non-significant result indicates the variance between groups is roughly equal and the assumption is tenable (Field, 2006). The results in Table 9 below show that the assumption of Homogeneity of variance has been met for the overall pre and post-therapy scores and each of their respective sub-scales.
Table 9 Levene’s tests for the overall pre and post therapy scores and each of the pre and post-sub-scale scores

<table>
<thead>
<tr>
<th></th>
<th>Levene Statistic</th>
<th>df1</th>
<th>df2</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall CORE Pre</td>
<td>.010</td>
<td>1</td>
<td>102</td>
<td>.922</td>
</tr>
<tr>
<td>Well-being</td>
<td>1.368</td>
<td>1</td>
<td>102</td>
<td>.245</td>
</tr>
<tr>
<td>Problems</td>
<td>.321</td>
<td>1</td>
<td>102</td>
<td>.572</td>
</tr>
<tr>
<td>Functioning</td>
<td>.840</td>
<td>1</td>
<td>102</td>
<td>.362</td>
</tr>
<tr>
<td>Risk</td>
<td>.006</td>
<td>1</td>
<td>102</td>
<td>.941</td>
</tr>
<tr>
<td>Overall Core Post</td>
<td>2.542</td>
<td>1</td>
<td>102</td>
<td>.114</td>
</tr>
<tr>
<td>Well-being</td>
<td>1.476</td>
<td>1</td>
<td>102</td>
<td>.227</td>
</tr>
<tr>
<td>Problems</td>
<td>3.734</td>
<td>1</td>
<td>102</td>
<td>.056</td>
</tr>
<tr>
<td>Functioning</td>
<td>.592</td>
<td>1</td>
<td>102</td>
<td>.443</td>
</tr>
<tr>
<td>Risk</td>
<td>.271</td>
<td>1</td>
<td>102</td>
<td>.604</td>
</tr>
</tbody>
</table>

In addition to the assumptions of an ANOVA, an ANCOVA has two additional assumptions. The first is that the covariate and the DV (pre-and post-therapy scores) are independent of each other; this means that the covariate should not be different in the two groups (high and low training; high and low experience). This assumption can be tested with an independent samples t-test using the pre- therapy CORE scores as the DV; a non-significant result evidence that the ANCOVA assumption of independence between covariate and DV are met (Field, 2006).

The results in Table 10 below show that the t-tests for each of the CORE total and sub-scale, pre and-post scores are non-significant, indicating that the assumption of independence between the covariate and the DV, in both the training and experience groups have been met.
The findings of the t-tests also suggest that a core assumption of the analysis, which was that any significant findings would be due to therapist factors (training and experience) rather than client factors (e.g. distress levels) has also been supported.

<table>
<thead>
<tr>
<th>CORE scales</th>
<th>Training</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-therapy CORE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbeing</td>
<td>t(102)= .921, p&gt;.359</td>
<td>t(102)=-1.110, p&gt;.270</td>
</tr>
<tr>
<td>Problems</td>
<td>t(102) = .810, p&gt;.420</td>
<td>t(102)=-1.105, p&gt;.272</td>
</tr>
<tr>
<td>Functioning</td>
<td>t(102)= .236, p&gt;.814</td>
<td>t(102)=-.332, p&gt;.741</td>
</tr>
<tr>
<td>Risk</td>
<td>t(102) = -.067, p&gt;.947</td>
<td>t(102)=-.254, p&gt;.800</td>
</tr>
<tr>
<td>Total CORE</td>
<td>t(102) = .247, p&gt;.805</td>
<td>t(102)=-.566, p&gt;.572</td>
</tr>
<tr>
<td><strong>Post-therapy CORE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbeing</td>
<td>t(102) = .861, p&gt;.391</td>
<td>t(102)=-1.190, p&gt;.237</td>
</tr>
<tr>
<td>Problems</td>
<td>t(102) = .830, p&gt;.408</td>
<td>t(102)=-1.199, p&gt;.233</td>
</tr>
<tr>
<td>Functioning</td>
<td>t(102) = 1.108, p&gt;.270</td>
<td>t(102)=-1.189, p&gt;.237</td>
</tr>
<tr>
<td>Risk</td>
<td>t(102) = .684, p&gt;.495</td>
<td>t(102)=-.989, p&gt;.325</td>
</tr>
<tr>
<td>Total CORE</td>
<td>t(102) = 1.024, p&gt;.308</td>
<td>t(102)=-1.382, p&gt;.170</td>
</tr>
</tbody>
</table>

The second main assumption of an ANCOVA is Homogeneity of the regression slope: this is the assumption that the relationship between the covariate (CORE pre-therapy scores) and the outcome variable (CORE post therapy scores) is constant across the different groups (here high/low training and high/low experience) (Field, 2006). Therefore, if there is a relationship between the covariate and outcome measure in one group, it is assumed that there is a similar sized relationship between these variables in the other groups.
To check the homogeneity of the regression slope a customized ANCOVA was undertaken, whereby the overall end of therapy CORE scores were entered as the DV, therapists were the IV and the pre therapy CORE scores were entered as the covariate. The results of the test show that the relationship between the covariate and overall outcome scores was non-significant F(8,86) = .605, p = .771. These results indicate that the assumption of homogeneity of the regression slope is thus tenable.

**Initial distress of clients and overall treatment effectiveness:** The current study aimed to examine the impact of therapists experience and training on client outcome however this analysis assumed 1) all clients are clinically distressed prior to therapy (since it is not possible to improve from a beginning point of not clinically distressed) and 2) that overall treatment was effective meaning that post-therapy CORE scores moved into a category of less distress or into the normal range (remembering that clinically significant change is indicated by a downward shift in scores of 17 or more). The first assumption has already been checked (as above) and summary statistics for assumption 2 are presented in Table 11 below.

**Table 11** Summarises the minimum and maximum scores and sample means and sample standard deviations for client overall pre and post CORE scores

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE Pre</td>
<td>104</td>
<td>36</td>
<td>117</td>
<td>77.80</td>
<td>19.841</td>
</tr>
<tr>
<td>Core Post</td>
<td>104</td>
<td>8</td>
<td>124</td>
<td>52.03</td>
<td>28.286</td>
</tr>
</tbody>
</table>
Table 11 shows that prior to therapy, all clients scored above the clinical cut off score of 34 points. Thus, all the study participants were within the clinical range of distress prior to intervention. In addition, it can be seen from the range of pre-therapy CORE scores that the overall level of psychological distress in the study population is in the moderately-severe range, indicative of major issues with psychological functioning in the study population.

In terms of the post-therapy CORE scores, the minimum outcome score of 8 indicates that some clients moved into the non-clinical (Healthy) range on the CORE measure after treatment. However, the post-treatment mean is still above the non-clinical cut-off, indicating a significant level of distress in the clients post treatment. Nonetheless, the mean values show a trend towards decreases in overall levels of distress following intervention. Furthermore, given that a 17-point change in the total score is indicative of reliable clinical change (as discussed in the Method section) the 25-point decrease in the mean from 77.8 to 52.03 also suggests a broad shift from the moderately-severe to moderate levels of distress as measured by the CORE, with many clients following treatment falling into the ‘mildly distressed’ population. The increase in standard deviations does also show a wider dispersion of scores post intervention (also indicated by the differences between the minimum and maximum scores: 8-124). Overall therefore, the results reflect a significant shift in distress for the clients but not a move into a non-clinical range of functioning as measured by the CORE.
Table 12 Sample means and sample deviations for each of the subscales of CORE pre and post intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-scores</th>
<th>Post-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellbeing</td>
<td>12.62 (SD 12.39)</td>
<td>7.45 (SD 4.21)</td>
</tr>
<tr>
<td>Problems and symptoms</td>
<td>33.55 (SD 7.73)</td>
<td>23.41 (SD 12.05)</td>
</tr>
<tr>
<td>Functioning</td>
<td>26.73 (SD 8.24)</td>
<td>18.79 (SD 9.92)</td>
</tr>
<tr>
<td>Risk</td>
<td>5.37 (SD 4.61)</td>
<td>2.95 (SD 4.86)</td>
</tr>
</tbody>
</table>

The mean values in Table 12 indicate broad trends of decreases in severity scores on each of the four sub scales, therefore reflecting improvements in each of these areas of functioning. The standard deviations show a slight tendency for a wider dispersion of scores post intervention indicating variability in the outcomes of individual clients.

**Impact of therapists on client change:** This study aimed to examine whether some therapists are more effective in terms of effecting client outcome scores. Summary statistics for the influence of therapists on therapeutic change (pre-treatment scores minus post treatment scores) are shown below in Table 13. Larger means are indicative of the therapist achieving, on average, larger shifts in their client’s functioning, as assessed in terms of client’s self-reported pre-and post-therapy CORE scores.
Table 13 The mean change scores and standard deviations for each individual therapist

<table>
<thead>
<tr>
<th>Therapist</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-41.5789</td>
<td>22.29</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>-16.5385</td>
<td>29.55</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>-23.9000</td>
<td>20.49</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>-20.8824</td>
<td>23.37</td>
<td>17</td>
</tr>
<tr>
<td>7</td>
<td>-23.8571</td>
<td>25.16</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>-18.1667</td>
<td>20.43</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>-28.5714</td>
<td>20.80</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td>-19.8750</td>
<td>35.22</td>
<td>8</td>
</tr>
<tr>
<td>14</td>
<td>-29.5714</td>
<td>32.96</td>
<td>7</td>
</tr>
</tbody>
</table>

As can be seen in Table 13 above, visual inspection suggests there was a range in the mean change scores between therapists. These results suggest that the therapists in the sample vary in their level of effectiveness. However, given the different number of clients per therapist, this trend must be held tentatively.

Table 14 The mean change scores and standard deviations for the training and experience groups

<table>
<thead>
<tr>
<th>Groups</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>low training</td>
<td>59</td>
<td>23.7119</td>
<td>24.62551</td>
</tr>
<tr>
<td>high training</td>
<td>45</td>
<td>28.4667</td>
<td>26.63269</td>
</tr>
<tr>
<td>Low experience</td>
<td>52</td>
<td>28.4808</td>
<td>25.74573</td>
</tr>
<tr>
<td>High experience</td>
<td>52</td>
<td>23.0577</td>
<td>25.20070</td>
</tr>
</tbody>
</table>

As can be seen in Table 14 above, visual inspection suggests that there are differences in the level of change between the low and high training and experience groups respectively. However, the differences appear small and thus further analysis would be required.
Impact of number of sessions on client outcome: This study aimed to examine the impact of individual therapists on client outcome. Length of therapy is a variable that in the service under study was jointly negotiated so it is not a therapist variable per se. Nonetheless it is possible that some therapists might routinely suggest longer contracts to clients. Since, as discussed in the literature, there is some research that suggests that therapists are more likely to be effective with clients the more time they have, it was important to examine the relationship in this study between client outcome and session length. For this reason, it was decided to conduct a linear regression with the number of sessions as the IV and client outcome (as assessed by the post-CORE total score) as the DV. The results of the analysis showed that there is no significant relationship between the number of sessions and client outcomes $F(41,62) = .757, p = .828$ (M = 52.03, SD = 28.27) in this study. These findings indicated that the number of sessions of therapy did not influence clients’ overall outcome scores; for this reason it was decided not to include number of sessions as an additional co-variate in the analyses.

Summary statistics for the training and experience groups on the overall post therapy scores: this analysis investigates whether the clients of therapists with more or less training and experience differ in terms of their therapeutic outcomes. Thus, Table 15 shows the means (and SD’s) for each of the training and experience groups respectively.
Table 15 Summary statistics for the training and experience groups and overall post therapy scores

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>low training</td>
<td>54.51</td>
<td>28.78</td>
</tr>
<tr>
<td>high training</td>
<td>48.78</td>
<td>27.61</td>
</tr>
<tr>
<td>Low experience</td>
<td>48.21</td>
<td>26.56</td>
</tr>
<tr>
<td>High experience</td>
<td>55.85</td>
<td>28.29</td>
</tr>
</tbody>
</table>

As can be seen in Table 15 above, the mean values for the training groups indicate a trend towards the high trained therapists achieving lower outcome scores (indicating less distress) than therapists in the low trained group. This suggests that therapists in the high training group achieved better therapeutic outcomes than their colleagues in the low training group however this is formally tested in the main analyses below.

The means for the experience groups show that therapists in the low experience group can be seen to be lower than for the therapists in the high experience group. This suggests a trend towards the therapists in the low experience group achieving better outcomes than their colleagues in the high experience group.

Summary statistics for each of the four sub scales and end of therapy scores for training and experience as shown below in Table 16.
Table 16 Summary statistics for the training and experience groups and outcome scores on each of the four sub scales

<table>
<thead>
<tr>
<th>Groups</th>
<th>Well being</th>
<th>Problems</th>
<th>Functioning</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>low training</td>
<td>Mean</td>
<td>7.76</td>
<td>24.27</td>
<td>19.73</td>
</tr>
<tr>
<td>high training</td>
<td>Mean</td>
<td>7.04</td>
<td>22.29</td>
<td>17.56</td>
</tr>
<tr>
<td>Low experience</td>
<td>Mean</td>
<td>6.96</td>
<td>22.00</td>
<td>17.63</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>3.97</td>
<td>10.95</td>
<td>9.81</td>
</tr>
<tr>
<td>High experience</td>
<td>Mean</td>
<td>7.94</td>
<td>24.83</td>
<td>19.94</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>4.43</td>
<td>13.01</td>
<td>9.99</td>
</tr>
</tbody>
</table>

The mean for the training groups show lower outcome scores across all subscales for the therapists in the high training group. This suggests that the therapists in the high training groups gained better outcomes across all domains than the therapists in the low training. This suggests a positive influence of training on therapeutic outcomes.

The summary statistics for the experience groups show that the therapists in the low experience group gained lower means across each sub scale than those in the high experience group. This suggests an inverse relationship between experience and therapeutic outcomes. In the next section the mean differences in CORE post-therapy scores in the training and experience groups are statistically analysed.
Main analyses

**Impact of therapists on client overall CORE outcome scores:** To test the hypothesis ‘Do client end of therapy scores vary depending upon the therapist?’, an analysis of covariance was conducted using the therapists as the independent variable and total post therapy scores on CORE as the dependent variable. The covariate was client overall pre-therapy scores on CORE.

The results of the ANCOVA indicated that there were no significant differences in the means of client end of therapy scores depending upon their therapist, F(8,94)=1.331, p=.238 (M=52.03, SD=28.29). These results suggest that no statistically significant differences between the therapists within the sample in terms of their clients’ post-therapy CORE scores were found.

**Impact of therapists on each of the sub scale end-of-therapy CORE scores:** To examine if end of therapy scores on each of the sub-scales varied due to their therapist, four individual analysis of covariance were conducted for each CORE sub-scale: Wellbeing, Problems, Functioning and Risk. Each analysis was conducted using the therapists as the independent variable and the total sub scale scores for the dependent variable. The covariate was the respective pre-therapy sub scale scores. As can be seen in Table 17 below, each of these analyses were statistically non-significant, indicating that each therapist was not differentially effective in their therapeutic work.
Impact of training on overall end of therapy scores: To test the hypothesis, ‘Do clients overall end of therapy scores vary depending upon their therapists level of training’, an analysis of covariance was conducted. The grouping variable was the therapist’s level of training with the clients being organized into two groups according to the level of their therapist’s training (High or Low) (as described in the methodology section). Client overall end of therapy CORE scores were used as the dependent variable and the covariate was client overall pre-therapy scores.

The results of the ANCOVA found no significant differences between clients overall end of therapy scores depending upon their therapists level of training, F(1,101)=1.057, p=.306 (M=52.03, SD=28.29). This result suggests that the therapists in both groups were equally effective (Low M=54.51, SD=28.78; High M=48.78, SD=27.61), thus that their level of training did not influence client overall end of therapy scores on the CORE.

Impact of therapist’s level of training on end of therapy sub scale scores: As before, in order to examine whether client outcome scores on the four CORE sub-scales varied due to

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>df</th>
<th>F value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well being</td>
<td>7.45 (4.21)</td>
<td>8.94</td>
<td>.968</td>
<td>.466</td>
</tr>
<tr>
<td>Problems</td>
<td>23.42 (12.05)</td>
<td>8.94</td>
<td>.532</td>
<td>.830</td>
</tr>
<tr>
<td>Functioning</td>
<td>18.79 (9.92)</td>
<td>8.94</td>
<td>1.624</td>
<td>.128</td>
</tr>
<tr>
<td>Risk</td>
<td>2.95 (4.86)</td>
<td>8.94</td>
<td>1.661</td>
<td>.118</td>
</tr>
</tbody>
</table>
therapist level of training four analyses of covariance were conducted, one for each sub-scale. The grouping variable was the therapist’s level of training and the dependent variable was the end of therapy sub scale scores. The covariate was the respective pre therapy sub-scale scores. The results shown in Table 18 below are all statistically non-significant. These findings suggest that the therapist’s level of training did not influence the outcome scores on each of the sub-scales of CORE.

**Table 18 Outcomes of the analysis of covariance for each of the CORE sub-scales and therapist level of training**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>df</th>
<th>F value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well being</td>
<td>7.45 (4.21)</td>
<td>1,101</td>
<td>.794</td>
<td>375</td>
</tr>
<tr>
<td>Problems</td>
<td>23.41 (12.5)</td>
<td>1,101</td>
<td>.280</td>
<td>.598</td>
</tr>
<tr>
<td>Functioning</td>
<td>18.79 (9.92)</td>
<td>1,101</td>
<td>1.262</td>
<td>.264</td>
</tr>
<tr>
<td>Risk</td>
<td>2.95 (4.86)</td>
<td>1,101</td>
<td>.600</td>
<td>.441</td>
</tr>
</tbody>
</table>

**Impact of therapists experience on overall end of therapy scores:** To test the hypothesis ‘Do client end of therapy scores vary depending upon their therapists experience’ an analysis of covariance was conducted. The grouping variable was the therapist’s experience with the clients being organized into two groups according to the level of their therapist’s experience (High or Low). Client overall end of therapy scores were used as the dependent variable and the covariate was client overall pre-therapy scores.

The results of the ANCOVA showed that there were no significant differences between client overall end of therapy scores depending upon their therapists level of experience,
F(1,101)=1.582, p=.211 (M=52.03, SD=28.29). These results indicate that therapists with different levels of experience (Low M=48.21, SD=26.56; High M=55.85, SD=29.68) were as equally effective in their therapeutic work.

**Impact of therapists experience on end of therapy sub scale scores:** In order to examine whether client outcome scores on the four CORE sub-scales varied due to therapist level of experience a series of ANCOVAs were conducted, again using the client outcome scores as the DV and the pre therapy scores of the respective sub scale as the covariate. The results, which can be seen in Table 19, showed that again there were no statistically significant differences between the Experience groups on any of the CORE sub-scales.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>df</th>
<th>F value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well being</td>
<td>7.45 (4.21)</td>
<td>1,101</td>
<td>1.512</td>
<td>.222</td>
</tr>
<tr>
<td>Problems</td>
<td>23.41 (12.05)</td>
<td>1,101</td>
<td>.632</td>
<td>.428</td>
</tr>
<tr>
<td>Functioning</td>
<td>18.79 (9.92)</td>
<td>1,101</td>
<td>1.352</td>
<td>.248</td>
</tr>
<tr>
<td>Risk</td>
<td>2.95 (4.86)</td>
<td>1,101</td>
<td>.930</td>
<td>.337</td>
</tr>
</tbody>
</table>

In summary, the analyses did not identify overall or sub-scale variability between therapists in terms of their effectiveness with client outcomes. Additionally, no effects of training and experience were found.
Discussion

The purpose of this study, in the first instance, was to examine if client outcome scores differed depending upon therapist. The effects of therapist training and level of experience on outcomes was also explored.

The analyses did not identify overall differences in client outcomes dependent upon therapist. Therefore, therapists were not shown to vary in their levels of therapeutic effectiveness. Additionally, no support was gained for the individual effects of training or experience on overall end of therapy scores. Equally, further statistical investigations of the influence of these variables on the CORE subscales did not reveal significant results. Therefore, no support for overall therapist variability or for the influence of therapists training and experience on outcomes was established. A non-statistical trend towards more highly trained therapists gaining better outcomes was identified. These findings will be discussed in turn, although it should be noted that some points could be viewed as possible suggestions for understanding the outcomes of both training and experience.

Therapist variability: It has come to be appreciated that different therapies are broadly equally effective (Stiles et al., 1986) and that outcome differences are at least as well explained by therapists variables as by ‘technique’ variables (Norcross, 2011). This suggests the importance of examining the impact of therapist variables on client outcomes, in particular since there is empirical evidence that some therapists are better than others at producing positive outcomes (Albert, 1997; Jennings and Skovholt, 1999). In respect of this view, the most striking and unexpected finding of the present investigation was that no significant differences between therapists were found, therefore suggesting that each of the therapists within the study population were as equally effective in producing positive
outcomes. These results are in contrast to the general findings within the literature base (e.g. Kim et al., 2006; and Okiishi et al., 2003). It is noted however that in an extensive review by Critis-Christoph and Mintz (1991) it was found that therapist variability can vary from 0% to 50% between studies which places the present results within the expected range.

An alternative explanation is that the study findings say more about the study design than about the research question. It may be that the lack of positive results could have been due to the small sample size and in turn, statistical power. For instance, the size of the sample being used has a profound effect on the statistical significance of the findings. Therefore, ‘the larger the sample the more accurate the estimate will be’ (Cooligan, 2005, p327). Thus, the small sample made it unlikely that an effect would be found and in turn it is probable that a Type II error occurred whereby there is an effect but it has been missed due to the reduced power of the test (e.g. Field, 2006). It is noted however that this explanation also contradicts the positive findings of other smaller and more equivocal studies such as that conducted by Orlinsky and Howard (1980); therefore indicating that other factors are probably playing a contributory role.

A further methodological issue to be considered is that of ‘randomisation’. Some prior studies have explicitly randomised the allocation of clients to therapist when undertaking their investigations. True randomisation is difficult to achieve, however, when implemented it reduces a range of biases which may otherwise muffle the impact of therapist differences in effectiveness. In the current study however, since it was conducted within a naturalistic NHS setting, randomization was not possible. A truly randomised process has ethical implications, for example, clients have no choice in which therapy they have and this can
impact upon expectations and motivation which can negatively impact upon therapeutic success (Brewin and Bradley, 1989). Thus the current study balanced research and service interests which may have had an impact on the ability of the investigation to uncover differences in therapist effectiveness.

The present investigation, due to its retrospective design, was not able to use randomisation but incorporated a ‘stratified’ allocation process. Using this stratified approach may have negatively influenced the results in a number of ways. For example, clients were allocated to therapists depending upon the perceived level of skill of the clinician and the complexity of the treatment required. Thus, in theory, not all therapists worked with for instance, dual diagnoses and some only implemented more structured and/or behavioural interventions. Therefore, in line with the suggestions made by Burlingame et al. (1989), it could be said that although pre therapy distress scores were accounted for during the analyses, potentially some therapists would have worked with more complex clients and gained similar outcomes but greater clinical changes may have occurred to achieve the same level of functioning by the end of therapy. This line of thought can be further supported by the fact that some therapists only implemented behavioural interventions and behavioural changes are both more sensitive to improvement and easier to measure (Stein and Lambert, 1984).

In line with suggested methodological criteria (Elkin et al., 2006), the present study incorporated client-rated questionnaires and not therapist-rated scales as these are seen to bias outcomes. Nonetheless, when responding to the CORE (and other questionnaire measures), quite different clients can produce the same score. For example some clients minimise their distress when answering the questions, while others are more prone to
‘respond high’, in part using the questionnaire to signal their distress to the therapist and service. Therapist outcomes may have therefore been statistically similar but clinically quite variable. Future investigations with more client information would be needed to unravel these issues further.

In terms of the study design, the current study incorporated recommendations by Kim et al. (2006), using a simple pre-post design, with the pre-therapy scores entered as the covariate. Despite such similarities in design however, the findings between the current investigation and that conducted by Kim et al. (2006) were inconsistent, possibly due to the different statistical procedures used (Hox, 2010). Thus, the present investigation drew upon analysis of covariance and Kim et al. (2006) used multi level modelling techniques. As discussed however, many studies within the literature base have also used analysis of covariance and still identified variations between therapists (e.g. Antonuccio, et al., 1987; Huppert, et al., 2001; Vocisano, et al., 2004).

A plausible alternative explanation for the study findings could be based on the sample of therapists used. Only 9 of the overall 22 members of staff were included in the study due to therapists only being eligible for inclusion if they had enough clients in the identified sample (minimum 5) and if they also had completed the training/experience questionnaire; since less than half of the therapists were included in the final sample, it is questionable if the sample was truly representative of therapists generally or specifically within the department. In other words, the therapists that were not included in the study may have been qualitatively different in some way (e.g. Hilliard, et al., 2000; Schacht and Strupp, 1990). For instance, some therapists may have been reluctant to engage with outcome monitoring possibly due to fear of exposure, however, those included may have been more
eager to please (e.g. Gilbert, et al., 2005). Equally, the therapists not included may have been restricted by caseload numbers and/or risks and therefore, time management issues, low motivation or burnout may have also developed as prominent contributory factor (e.g. Saxon and Barkham, 2012). Thus a different sample may have yielded results more characteristic of those found within the literature base.

**Training:** The second aim of the study was to investigate the effects of therapist training on therapeutic outcomes. The results of the investigation did not find any statistically significant effects of training on overall outcome scores or sub-scale scores. These results do not provide support for overall or differential effects of the influence of therapist level of training on therapeutic outcomes (Thompson et al., 1983; Stein and Lambert, 1995). This finding was in line with the reviews conducted by Durlak (1979) and Berman and Norton (1985). However, in contrast to the studies within those reviews, the present investigation incorporated methodological improvements such as the use of outcome measures (e.g. Nietzel and Fisher, 1981), information on specialist training (e.g. Howard, 1999), and a stratified approach to grouping the therapists in an attempt to untangle the compounding nature of training and experience (e.g. Stein and Lambert, 1984). Despite the overall non-significant findings, a tentative trend towards higher trained therapists gaining more positive outcomes than their lower trained colleagues was observed.

In line with the suggestions made by Strupp and Hadley (1979) following their comparative study on therapists and lecturers, one possible explanation for these statistically negative findings may be that the therapists in the study sample were more similar than different. For instance, firstly, the grouping arrangements of the therapists resulted in the therapists in the low training group having high experience and the therapists in the high training...
group having low experience. Therefore, in addition to the possible compounding nature of these variables, it could be argued that therapists in the higher training group had more knowledge but fewer therapeutic skills to utilise that knowledge and conversely, the lower group of therapists had lower levels of academic or theoretical knowledge but more skills to draw on their knowledge base. Thus, it could be said that different aspects or types of training have differential effects on outcome but collectively, equate to greater similarities rather than differences between therapists (Stein and Lambert, 1984). This is further supported by Fals-Stewart and Birchler (2002) whereby they found that BSc and MSc students were equal on adherence to manuals but the MSc students presented with greater competence and better outcomes overall.

It is suggested that to develop further understanding of the influence of training on outcomes, future studies would benefit from investigating training as a holistic variable while simultaneously examining individually its constituent parts. That being said, a particular aim of the present study was that in line with the suggestions made by Beutler, (1997) it incorporated a more complex and comprehensive conceptualisation of ‘training’ than any other study known to the researcher; whereby previous studies commonly defined training in terms of academic degrees, the present study incorporated additional information on length of training, supervisory training, and specialist therapeutic training. However, despite the inclusion of such additional information, no common trends across the data were observed and therefore the therapists were grouped on the strongest trend of ‘level of training’. Thus, it could be said that although additional training data was ‘theoretically’ accounted for, statistically this was not the case. It could therefore be said that the present study did not achieve this aim in its entirety.
Another possible explanation for the lack of overall effects of training could be related to the use of relational factors such as the core conditions (Lambert, DeJulio, and Stein, 1978; Rogers, 1957), and the effect that all therapists in the sample had regular supervision (Division of Counselling Psychology, 1998; Strupp and Hadley, 1979). In terms of the core conditions, although not explicitly measured within the study, as a member of the studies department, the researcher has knowledge that some of the ‘in house’ CPD events encompassed training on the person-centred approach and specifically the core conditions. Therefore with this in mind, it could be argued that the therapists in the sample population were equally effective in developing a good therapeutic relationship, which would have significantly influence outcomes (Orlinsky et al., 1994; Machado and Neufeldt, 1994) and played a central role in effective therapeutic change (e.g. Horvath and Symonds, 1991). This explanation, potentially, would further compound the complexities of the previous points made around training specificity, and provides further support for the possibility of greater similarities than differences between the therapists in the study.

A final explanation to why overall differences were not found may lie in the fact that all of the therapists received regular supervision (Brightman, 1984; Division of Counselling Psychology, 1998). Additionally, all therapists were supervised by more highly qualified and experienced members of staff (Strupp and Hadley, 1979). However, given that supervision is an experiential learning process that encompasses aspects such as modelling and developing interviewing techniques (e.g. Jennings, 1996), it could be argued that therapists with no or little formal therapeutic training did in fact have more than appeared from their answers about formal training in the audit questionnaire. This in turn would have positively influenced their outcomes. Conversely, the supervisory process for more qualified staff
would have been in a more consultative and collaborative format rather than more practice-based learning (Friedman and Kaslow, 1986). These differences again could potentially narrow the variability between the therapists.

**Experience:** The present study did not reveal overall or differential effects of therapist experience on therapeutic outcomes. However, on visual inspection of the data, therapists in the low experience group appeared to gain better outcomes than their more experienced colleagues. Given the inverse relationship of training and experience identified between the groups however, these results could potentially suggest that training rather than experience has the greater influence on therapeutic outcomes.

Statistically, these results are in contrast to the general reports from the reviews conducted by Bergin (1971) and Smith and Glass (1977). Interestingly however, the observed trend, that less experienced therapists gained better outcomes, are more in line with the results of the meta-analysis conducted by Shapiro and Shapiro (1982) since these researchers also identified better outcomes by less experienced therapists. However, when they controlled target problems, experience in this study no longer impacted on outcomes. Therefore in a similar vein and as discussed earlier in relation to training, the non significant results of the present investigation may have possibly been influenced by the complexity of both client presentations and therapeutic interventions (Stein and Lambert, 1984): whereby due to the stratified design, therapists in the low experience group may have seen less complex clients and used less complex or behavioural style investigations (Stein and Lambert, 1984).

Additionally, this explanation can be further supported by the more recent finding of Luborsky et al. (1997), whereby more experienced therapists were found to produce better outcomes with a range of presentations and less experienced therapists were only effective
with certain types of clients. Thus, future studies would benefit from incorporating more detailed information about these issues into their investigations.

Further explanations for the lack of influence of experience on outcomes may be similar to those discussed within the training literature. For example, less experienced therapists may have used the core conditions to enhance the therapeutic relationship and in turn improve their outcomes (Rogers, 1957). This conclusion however, contradicts that presented by Auerbach and Johnson (1977), whereby they suggested that more experienced therapists develop better relationships than novice therapists and overall have better outcomes. Nonetheless, their conclusions were ‘weak at best’ and thus, it could be argued that the currently proposed explanation cannot be excluded at this time as research is clearly in its infancy in relation to understanding the complexities of experience and its influence on outcomes (e.g. Beutler, 1997).

An alternative explanation of the lack of a statistically significant relationship between therapist experience and client outcomes might be due to the type of ‘experience’ that the therapists had. For instance, it can be said that some therapists repeat the same experiences while others participate in ongoing learning (formal and informal) which works to constantly refine their knowledge and skills ultimately their therapeutic competence (Skovholt, Ronnestad, and Jennings, 1997). For example, it may be the case that the enthusiasm of less experienced therapists encourages them to engage with new experiences in a way that some more experienced therapists do not, which could potentially place all the therapists at more similar rather than different experiential levels.

Additionally, developmental processes should also be considered. For example, less experienced therapists, as part of their learning, generally engage in a range of activities,
while more experienced therapists usually have bigger therapeutic caseloads and hence less space for exploration. These processes by themselves can lead longer standing therapists into a halted learning state not only by repetition but also by the fact that the hours spent doing therapy may not necessarily be the critical part of experience that leads to more positive outcomes (Huppert et al., 2001). Therefore, it could be said that their learning and development opportunities are reduced. Simultaneously, with a tentative trend towards more experienced therapists having greater therapeutic caseloads identified in the current study, the issues of possible boredom or even burnout should also be considered (Kovacs, 1976). Conversely, progression may have a different meaning or level of importance for therapists within different stages of the lifespan: within the sample population, there seems to be a tentative relationship between therapist age and experience. Therefore, more experienced therapists may have reached their personal career goals and may not feel they want or need to progress any further. In contrast however, less experienced therapists are presumed to be still striving towards their goals and career progression.

Finally, it can be said that the results of this investigation certainly add support to the conclusion that research in this area clearly needs to continue (e.g. Stein and Lambert, 1995). The current investigation is not only one of the very few studies to look at experience independently but it has also added to the literature base by providing a more comprehensive and complex conceptualisation of the variable (Beutler, 1997). Also, while many of the studies conducted to date have generally used samples of less experienced therapists only (e.g. Bergin, 1971; Stein and Lambert, 1984), the present investigation incorporated therapists with a vast range of experience and therefore, to not statistically find overall effects was unexpected.
A further comment needs to be made about the limitations of the sample in this study. The assumption of this study was that the training and experience groups would be different; the findings that those practitioners with higher training were also those with lower levels of experience was not expected. The finding of this inverse relationship also has implications for the individual results of training and experience. Thus, the analyses for both variables were in essence a replica of the other. That being said, what has been identified, although not statistically, is that therapists with high training and low experience appear to tentatively gain better outcomes than their colleagues with high experience and low training. This observational finding in part could suggest that overall training may be more influential than therapist’s experience. This proposal can also be seen to parallel the overall more robust support for the influence of training within the current literature base. However this is a rather speculative conclusion given the lack of statistically significant findings and the issues identified with the study design and sample.

Limitations of the Study

This study has a number of limitations. As stated previously, some of these limitations included: 1) the lack of random assignment of clients to therapists, 2) a small sample size and possible power effect, 3) a lack of additional client information and 4) the inverse relationship between the training and experience variables which narrowed the breadth of the investigation.

However, additional limitations exist. First, the present study incorporated retrospective data that was collected at one time point using a single self-report measure; the study findings must be interpreted in this context. Additionally, this design did not allow for the study to incorporate follow-up data which could have shed light on whether the benefits of
therapy were firstly maintained and secondly, to see if therapist differences would have emerged. Simultaneously, there was an inability to examine further information about the therapists such as how they thought and felt about their work. Client and peer perceptions of the therapist’s would have also been valuable information.

It is proposed however, that the main limitation of the study was, with hindsight, the difficulties with defining training and experience clearly and comprehensively. The aim of the study was to create more robust and complex training and experience variables than previous studies within the literature, however the discussion has outlined the ways in which this aim was not accomplished. Thus, different learning pathways seemed to have rendered the therapists more similar than different. Additionally, it could be argued that the sample of therapists was relatively highly academically and experientially qualified in comparison to many studies within the literature base. This issue renders the present investigation to be the polar opposite of previous studies whereby study populations encompassed therapists with low training and experience (e.g. Stein and Lambert, 1984)). A key conclusion of this study therefore is that there needs to be more attention paid to developing theoretically and empirically robust definitions of ‘training’ and ‘experience’.

**Future Research**

The field of therapy assumes that practitioners should be trained and typically rewards higher training and experience practitioners with more senior roles, more status and better salaries. However, as discussed, there remains a lack of clear empirical evidence that (higher levels of) training and experience creates better outcomes for clients. Thus additional studies of this nature are certainly warranted, particularly within organisations such as the NHS which have historically and currently invested significant financial resources towards
paying for staff training (e.g. clinical psychology or IAPT trainings as well as CPD programmes). Such investigations would benefit from larger therapist samples and a greater number of clients per therapist. This would enable investigators to use more powerful statistical techniques such as HLM and in turn provide a greater likelihood of finding significant differences. Incorporating larger sample sizes would also allow for a greater range of training and experience between therapists. This in turn would not only enable a closer examination of the influence of these variables by for example, separating therapists into a greater number of hierarchical groups but this would also minimise the likelihood of the development of an inverse relationship between the variables, which by their original nature are already compounded.

Future research would also benefit from adding to the comprehensive conceptualisation of the training and experience variables and should also look at the constituent parts of each of the variables on an individual basis. These individual investigations could potentially highlight which aspects of training or experience are most influential towards therapeutic change. Hence, are there differential effects and not just a blanket effect of these variables on outcomes? Additionally, such information could potentially guide training courses to develop more specific and/or relevant training criteria.

Additionally, it is suggested that future studies incorporate a qualitative section to their investigations (for instance by drawing on the literature base of, for example, master therapists, and client experiences of helpful and unhelpful aspects of therapy). Thus, such qualitative investigations have the potential to shed light on both statistically significant and non significant results by developing understanding of why some therapists are better than others. For example, therapists could be asked about what they think their personal
qualities or skills are that contributes to positive therapeutic change. Or alternatively, clients could be asked what was important about their therapist that made their experience of therapy more positive.

**Implications for Practice**

On an initial (and superficial) inspection of the study findings, it could be said that training and experience do not impact therapeutic outcomes in real world practice. However it is argued that given that the sample of therapists were all relatively highly qualified and all gained positive outcomes, experience and particularly training are both likely to be important in everyday clinical practice but that issues with the study design and sample may have prevented this being clear in terms of statistically significant results. The first implication of this proposition is to achieve and maintain good ethical standards of practice (BACP, 2010). For instance, having a well trained and experienced workforce reassures and respects service user perceptions and expectations that they are entering a service that strives to provide ‘high quality care’. Simultaneously, service providers that work within organisations that highlight the importance of quality care are supported to value their ongoing dedication to developing and maintaining such standards of practice. This in turn, contributes to further confidence and competence of staff. For example, within the boundaries of their knowledge and skills, therapists are more able to choose the most appropriate course of intervention, develop an alternative course of action in light of difficulties and would be able to justify their actions on theoretical and ethical grounds. Therefore overall, the greater the knowledge, skill and competence of therapists, the greater the likelihood that harm to clients will be avoided and their general well-being will be improved (BACP, 2010; BPS, 1993).
Additionally, from a service perspective, knowing the skills and experience levels of staff is also of importance. Firstly, it highlights the current competencies of staff and thus in turn, identifies future training requirements. Secondly, the study findings suggest that the role of regular supervision may also be of the utmost importance. Thus, it could be argued that large organisations such as the NHS would benefit from investigating the regular supervisory practices of their staff to ensure appropriate levels or frequencies of supervision are undertaken. For instance, more highly qualified or experienced staff should not necessarily have supervision less often but on the contrary, may need more regular supervision to ensure issues such as complacency, boredom and burnout are mindfully acknowledged and monitored. Simultaneously, it is suggested that staff would benefit from a variation of tasks within their clinical work to ensure that not only their competence but also their motivation and clinical practice is maintained. Also, it has been hypothesised that negative processes such as complacency and burnout may also be impacting upon clinical outcomes. Thus, it is suggested that both clinicians and senior staff within large organisation such as the NHS would benefit from not only looking to see what is ‘missing’ in terms of training and experience, but what is also ‘present’ and influencing the likelihood of therapists gaining better therapeutic outcomes.

**Conclusion**

This thesis set out to examine whether evidence could be found in a naturalistic NHS service setting that the ‘person of the therapist’ has a differential impact on client outcomes and that the therapist’s training and experience influence this impact. The study has not found clear evidence for these propositions. However, the discussion has outlined a number of issues with the study design and sample that may explain this result. In addition, the thesis
has argued that the study has revealed that it is in practice remarkably difficult to identify clear and robust training and experience variables.
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The effects of therapist training on the outcomes of psychological therapy within an NHS setting

Mandy Newman, Dr. Naomi Moller, and Dr. Paul Redford

1 The University of the West of England, Department of Psychology
2 The Open University, Department of Psychology
3 The University of the West of England, Department of Psychology

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*Requests for reprints should be addressed to Mandy Newman, 76 St Brides Road, Aberkenfig, Bridgend, S. Wales. (mandynewman@hotmail.co.uk).
Abstract

Objectives: While it is assumed that therapist training is important to ensure ethical and competent practice, there is a lack of evidence that links practitioner training to client outcomes. Thus, the aim of this study was to investigate the influence of therapist training on therapeutic outcomes within an NHS setting.

Methods: This study examined archival data collected on 109 clients seen by 9 therapists over a five year period (2007-2012) in one NHS Trust in Wales. The study incorporated client pre and post scores on the Clinical Outcomes in Routine Evaluation questionnaire (CORE: CORE Systems Group, 1998), and information about therapist training obtained from an ‘in service audit questionnaire’. A series of Analysis of Co-variance (ANCOVA) were conducted.

Results: Despite the fact that the average outcomes for the more highly trained therapists were observed to be higher, there was no statistically significant link between higher levels of therapist training and better client outcomes.

Conclusions: The non-significant finding is discussed in terms of potential problems with the study design as well as the underlying difficulty of clearly defining therapist training levels. The ongoing significance of the research question, the relationship between practitioner training and client outcomes, is also discussed.
Practitioner points

This research is relevant to clinical practice because:

- It empirically examines the influence of training on therapeutic outcomes in a naturalistic NHS context
- It stimulates debate about the role of therapist training in creating good client outcomes
- Each of the above contributes to maintaining good standards of practice
Introduction

It has been shown that therapist characteristics significantly influence psychotherapy (e.g. Kim, Wampold and Bolt, 2006). A range of therapist variables have been studied, including: therapist age (e.g. Beck, 1988), sex (e.g. Krippner and Hutchinson, 1990), race (e.g. Atkinson and Schein, 1986; Sexton and Whiston, 1991) and personality traits (e.g. Berry and Sipps, 1991). However, one of the most controversial variables to have been investigated is therapist’s level of training (e.g. Beutler, 2004).

The importance of practitioner training is enshrined in practitioner training standards (e.g. BACP, 2010; BPS, 1993); these standards are set up and reviewed to ensure that ethical and competent practice is undertaken in order to protect vulnerable clients and to create best outcomes. Yet while it is assumed that training is important for ethical and competent practice, it remains the case that it has been challenging to empirically evidence a connection between practitioner training and (better) client outcomes.

Early reviews (Breman and Norton, 1985; Durlak 1979; Stein and Lambert, 1984) all reported that paraprofessionals – that is those who do not have a formal qualification in working therapeutically- obtained equivalent outcomes to that of professional therapists. Many of these studies were however criticised on grounds, such as a: limited use of outcome measures and the use of unclear definitions of what constitutes a professional (e.g. Nietzel and Fisher 1981; Hattie, Sharples and Rogers, 1984). In addition it was argued (e.g. by Atkins and Christensen, 2001) that it was not appropriate to assume, as many of these studies did, that a paraprofessional practitioner did not have any training as they often received ongoing supervision (a form of training) from professional therapists (Strupp and Hadley, 1979). In
their review of research in this area Stein and Lambert (1984) also suggested that client’s level of distress might influence whether differences were found- with the impact of training potentially only becoming clear when client complexity and distress was higher.

Later studies contrasting trained and paraprofessional therapists did however find a more positive relationship between level of therapist training and client outcomes. For example, a 1995 review of 36 studies examining differences in client outcomes for trained and paraprofessional therapists, (Stein and Lambert, 1995) found modest effect sizes favouring professionals when client functioning was assessed before and after therapy (d=.30).

Trained therapists were also found to outperform their non-professionally trained colleagues in a 1998 study by Lave, Schulberg and Kamlet, specifically gaining more positive outcomes in relation to symptom reduction (Barlow, Burlingame, Harding and Behrman (1997).

Studies in this area have also compared therapists with different levels of training. For example, Strosahl, Hayes, Bergan, and Romano (1998) examined the effects of a training program for acceptance and commitment therapy (ACT) and found that the ACT-trained therapists completed therapy more quickly and gained better outcomes than the therapists within the control group. Howard (1999) similarly investigated the impact of specialist training for anxiety disorders and found that the specialist therapists completed treatment significantly faster than their non-specialist colleagues and had significantly lower rates of client relapse over a two year period following therapy. In one of the most recent studies, Fals-Stewart and Birchler (2002) compared undergraduate and post graduate training and found that master’s therapists showed greater competence and overall obtained better
outcomes than their undergraduate-trained peers, a finding that indicates that training should not be considered merely as a dichotomous variable but in terms of level of training.

While the more recent studies do suggest that therapist training has a positive impact on client outcomes, the lack of more recent research is problematic. In addition, the mixed findings to date suggest the potential complexity of the relationship between training and outcome, something that was illustrated by a 1983 study conducted by Thompson, Gallagher, Nies and Epstein which examined the differences between professionals and paraprofessionals conducting group therapy for depression in the elderly following an 8 week training program. The results showed that the training enhanced both the professionals and paraprofessionals knowledge of theory and therapy with equal improvements in: problem-solving skills and attitudes towards the elderly, levels of effectiveness, competence and the identified non-specific factors. Perhaps unsurprisingly given this evidence of equal benefits from the training, no overall statistically significant differences in terms of client outcomes were found between the groups at the end of therapy or at follow-up. However despite the lack of global differences in client outcomes there was evidence that participants from the professional-led group reported significantly higher scores on two subscales of the life satisfaction measure, higher levels of satisfaction with their therapy and rated their overall improvement as higher than participants in the paraprofessional-led groups. In summary, this study suggests that differences in client outcomes as related to differential therapist training might be quite subtle.

Taken together, the limited research in this area suggests the importance of studies employing both global and specific measures of client outcome in order to detect differences between service providers with different levels of training (Stein and Lambert,
Thus the current study employs both an overall and dimensional measure of client outcome with the total and sub-scale scores of the Clinical Outcomes in Routine Evaluation, (CORE-OM, CORE Systems Group, 1998). Critical review of the literature (Stein and Lambert, 1984) has also suggested that the impact of training differences may only be felt at higher levels of client distress. The current study included clients experiencing a range of clinical distress but the mean intake distress level was moderately severe. Lastly, the existing literature evidences the ongoing debate about how best to differentiate different levels of training as well as the difficulties with dichotomous training variables (e.g. Beutler, 1997); thus the current study sought to utilise a range of information to categorise training levels of the therapists in the study. The current study thus aimed to answer the question: What are the effects of therapist training upon client outcomes in a naturalistic NHS setting?

**Methodology**

**Design**

This study was approved by the Research Committee at the University of the West of England, Bristol; NHS ethics and Research and Development approval was not necessary because of the use of anonymised archival data. Approval from the clinical lead of the psychological therapies service was however gained for use of the Trust data.

The study was retrospective in nature and was based on existing archival data from one NHS Trust in Wales, which was collected between 2007 and 2012. At the time of data collection, the service accepted adult (aged 18-65) primary and secondary mental health care referrals from a range of health care professionals (e.g. general practitioners, occupational therapists and psychiatrists). The referrals encompassed a range of presenting difficulties (including
anxiety, depression, psychosis and personality disorders) and various levels of complexity, with co-morbidity being common. Individuals with an identified cognitive degenerative disorder such as dementia or a diagnosed learning disability were excluded from this service.

The client and therapist data analysed in this study were collected as part of the general working procedures of the study Trust and were held within archival records. Two verbal requests were put forward to the clinical lead to obtain the client and therapist data respectively. On receipt of the data, client-therapist pairs were identified via their NHS codes and in turn given new ‘study’ security codes to ensure that all stored data was fully anonymized.

**Data source:** For the identified 5-year period, 255 client records were located; incomplete data records (those without both pre and post CORE and a record of the total number of therapy sessions) were removed from the sample. Next client records were matched to therapists and only therapists with complete data (training and experience data, see below) and with at least 5 clients in the sample were included. This left a sample of 109 (est. 42.75% of the original dataset) completed pre-post therapy client data sets for analysis with these clients being seen by nine therapists.

**Clients:** The client sample consisted of 37 (33.9%) men and 69 (63.3%) women. The average age of the group was 43.96 years, ranging between 18 to 72 years. No additional demographic data was available. As assessed by CORE, the participants’ level of distress at the start of therapy ranged between 9 and 117, with a mean score of 75.06, which equates to a ‘moderately severe’ level of psychological distress (CORE Systems Group, 1998). Because the analysis was focused on change, individual’s scoring below the clinical cut off
point at intake were then excluded from the analysis; this left a final N of 104. The total number of therapy sessions completed by clients ranged between 2 and 65 (Mean=18.96) (see figure 3.2, p.33).

**Practitioners:** A total of 9 therapists (42.9% of the total number of therapists working in the department during the five-year period) were identified as having sufficient client data to be included in the analyses: complete pre and post data sets for a minimum of 5 clients. The 9 clinicians consisted of 4 nurse therapists, 1 trainee therapist, 2 psychologists, 1 trainee psychologist, and 1 assistant psychologist. The therapists were all British white females and ranged in age from 30 to 56 years (mean = 43.22 years). The therapist’s training ranged from diploma to doctoral level qualifications. Six were identified as having some form of additional specialist therapeutic training. The number of hours of therapeutic contact with clients ranged from 10 to 37 hours per week (mean= 19.86, SD=7.50). All therapists received regular supervision and seven of the nine therapists provided supervision to other members of staff, and five had completed supervisory training.

**Measures**

**Clinical Outcomes in Routine Evaluation – CORE OM** (CORE-OM: CORE Systems Group, 1998), is a standardised outcome measure designed for use within psychological therapies. The CORE-OM is not a diagnostic tool but a measure of self-reported global distress experienced by the individual over the previous week. In line with recommendations, in this study the questionnaire was completed before and after therapy. It consists of 34 items, all answered on a five-point scale ranging from ‘not at all’ to ‘most or all the time’. The measure has four sub-scales: subjective well-being (4 items), commonly experienced problems or symptoms (12 items), life functioning (12 items) and risk to self and others (6
items). Some of the items address low intensity difficulties and some high intensity problems in order to increase scoring range and sensitivity to change. In addition, 25% of the items are positively framed with reverse scores.

The instrument is problem scored, thus, the higher the score the more problems the individual experiences and the greater their level of distress. The instrument can be interpreted using three scoring formats: This study used total scores. Reliable change is indicated by a reduction of 17 or more on the total score, (CORE Systems Group, 1998).

Clinically significant change or sufficient improvement to have moved a client to a score more representative of the general population, is determined when a client’s score drops by 17 and moves below a severity boundary (CORE System Group, 1998).

The instrument has good levels of internal consistency with a Coefficient α of 0.75 and 0.95, in non clinical and clinical samples respectively (Evans, Cornell, Barkham, Margison, and McGrath, et al. (2002). Test-retest stability has also been evidenced, with correlations of 0.87-0.91 (Spearman’s p) found (Evans, et al., 2002). Convergent validity against a battery of existing measures has additionally been shown to be good. Finally, differences between the non-clinical and clinical samples were found to be ‘large and highly statistically significant on all domains’ (Evans et al., 2002,) and support found for the use of the clinical cut-off value 33 between the clinical and normal population (Cornell et al., 2007). In conclusion, the evidence suggests that the CORE-OM is a reliable and valid instrument to measure therapeutic outcomes (Evans, Connell, Barkham, et al., 2002).

*Therapist audit questionnaire*
The questionnaire was developed by the clinical lead and assistant psychologists in the study Trust as a survey of the expertise and experience of the current staff base. It consisted of 36 open and closed questions and encompassed contract details; academic and therapeutic training; CPD experience; supervision training and provision; caseload information; and general clinical issues. Open questions on training included: Please provide information on formal training, inclusive of name of course, level, duration and year of completion.

**Creation of the training variable:** One aim of this research was to provide a more sophisticated operationalization of training than is found in the existing literature. In the current study there were nine therapists each with data on four different aspects of training: level of training, years of training, had or had not obtained supervisory training, and had or had not obtained specialist therapeutic training (see Table 1). Contrary to expectation however, there were no apparent trends across the items. Therefore, the strongest ‘single item’ trend was identified - namely academic training (post-graduate versus non-post-graduate) and the therapists were grouped into two groups according to this item.

**INSERT TABLE 1 HERE**

**Data analysis:** Data were analysed using analysis of covariance (ANCOVA), to examine whether the mean post-therapy CORE score differed in the two groups of clients (those with therapists with high versus low training). Since higher experience practitioners may be given more distressed clients, the impact of different pre-therapy CORE score was statistically controlled by the pre-therapy CORE score being entered as the covariate. Including the baseline, pre-treatment scores as a covariate follows recommendations in the literature for statistical analyses aimed at evaluating treatment outcomes (e.g. Vickers and Altman, 2001).
A number of ANCOVA’s were undertaken: the first was conducted on the overall end of therapy CORE scores to examine overall effects of therapist training; this was followed by four further analyses, one for each of the CORE sub scales. On each occasion, the total or sub scale pre-therapy CORE scores were entered as the covariate.

Results

Exploratory and descriptive statistics

The key CORE outcome data was examined (Tukey, 1977) to assess potential violations of the underlying assumptions of the ANCOVA, in particular the normality of the data.

Table 2 provides the mean, SD, range, skew and Kurtosis for the CORE total and sub-scale scores at pre- and post-therapy.

[INSERT TABLE 2 ABOUT HERE]

A Kolmogorov-Smirnov test of normality was conducted to assess the normality of the pre-therapy CORE total scores: The results, D(104)=0.07, p<.05, M=77.8, SD=19.84) indicated that the variable was normally distributed.

A second Kolmogorov-Smirnov test was conducted to assess the normality of the post-therapy CORE total scores: the results, D(104)=0.12, p<.05, M=52.03, SD=28.29) indicated that the variable is not normally distributed.

Skewness and Kurtosis of the variables was also assessed; for the problem, functioning and risk scales, there were no large departures from symmetry as their respective absolute values were all less than one and the ratio of the calculated values of skew and Kurtosis to their respective standard errors did not suggest large departures from normality. The well
being scale however, did not meet the criteria for normality and hence results pertaining to this scale need to be interpreted with caution.

Skewness and Kurtosis were also assessed for post-therapy sub-scale scores: problems, functioning, well being and risk. The results showed non-significant (p<.01) Skewness and Kurtosis for the well being, problem, and functioning scales suggesting that the variables are normally distributed. However, the risk scale did not meet the criteria for normality and the results pertaining to this scale should be interpreted with caution.

One assumption specific to ANCOVAs is that the covariate is not at a different level in the analysis groups; for a two-group ANCOVA this can be tested by running a t-test on the covariate (pre-therapy scores) for the two groups (high and low training). The independence of the covariate and grouping variable is indicated by a non-significant result, (t(102)=.25,p>.05, M=.98, SE=3.95).

A further assumption of the ANCOVA is homogeneity of the regression slope: To check this assumption a customized ANCOVA was undertaken, with the overall end of therapy CORE scores entered as the DV, therapists as the IV and the pre-therapy CORE scores as the covariate. The results show that the relationship between the covariate and overall outcome scores was non-significant F(8,86) = .605,p =.771. This indicates that the assumption of homogeneity of the regression slope is tenable.

The current study aimed to examine the impact of therapists training on client outcome however this analysis is predicted on an assumption that overall treatment was effective (e.g. that client post-therapy CORE scores fell by 17-points and/or into the ‘non-clinically distressed’ range.)
As seen in Table 2, while the post-treatment mean was still above the non-clinical cut-off, indicating a significant level of distress in the clients post treatment, given that a 17-point change in the total CORE score is indicative of reliable clinical change the 25-point decrease in the mean does suggest the treatment had a clinically significant positive impact for most clients, moving the cohort from the moderately-severe to moderate levels of distress, with many clients following treatment falling into the ‘mildly distressed’ population. Inspection of the means for the sub-scale scores post-treatment equally indicates a decrease in severity scores on each of the four sub scales, reflecting improvements in each of these areas of functioning.

**Main analysis**

Table 3 provides descriptive statistics for the high and low training groups for the post-therapy CORE scales.

[INSERT TABLE 3 ABOUT HERE]

Visual inspection of the means in Table 3 show that the high trained therapists achieved average lower CORE scores than therapists in the low trained group, indicative of better outcomes (lower distress).

To formally test the impact of therapist training on clients’ post-therapy outcome scores, an analysis of covariance was conducted, with pre-therapy CORE scores as the covariate.

The results of the ANCOVA found no significant differences between clients overall end of therapy CORE scores depending upon their therapists’ level of training when pre-therapy
scores were controlled for: F(1,101)=1.057, p=.306 (M=52.03, SD=28.29). This result suggests that the therapists in both groups were as equally effective (Low M=54.51, SD=28.78; High M=48.78, SD=27.61) and that their level of training did not influence client overall end of therapy scores on the CORE.

To examine whether client outcome scores on the four CORE sub-scales varied due to therapist level of training four additional analyses of covariance were conducted, one for each sub scale. The results of these analyses can be seen in Table 4: These findings suggest that the therapist’s level of training did not influence the outcome scores on each of the sub-scales of CORE.

[INSERT TABLE 4 ABOUT HERE]

**Discussion**

The purpose of this study was to examine if client outcome scores on a widely used measure of client distress, the CORE, differed depending upon the therapists’ level of training (post graduate or not). Statistical analysis did not show an effect of therapist training despite mean outcome scores for the higher trained group that were indicative of less psychological distress in the clients at the end of therapy.

In line with Durlak (1979) and Berman and Norton (1985), these results do not provide support for overall or differential effects of the influence of different levels of therapist training on therapeutic outcomes (e.g. Stein and Lambert, 1995). In contrast to much of the prior research which historically have focussed on comparing practitioners with training with those without any formal training, the present investigation incorporated
methodological improvements including the use of a standardised and well validated outcome measures (e.g. Nietzel and Fisher, 1981), and a stratified approach to grouping the therapists (focused on diploma and undergraduate versus post-graduate training qualifications) in an attempt to build upon current conceptualisations of ‘training’ (e.g. Stein and Lambert, 1984). The result is of interest not least because it contradicts more recent research in the area and thus it is important to consider potential explanations.

The first (obvious) explanation is that training level does not in and of itself make practitioners more effective. For example, common factors in therapy, including therapeutic relationship factors have been argued to be important in terms of client outcomes and it may be that these key therapeutic skills are equally well taught in Diploma and Undergraduate as Post-graduate training programmes, which would have influenced outcomes (e.g. Orlinsky et al., 1994). This explanation, would suggest the possibility of greater similarities than differences between the therapists in the study.

A similar argument may be made from the fact that all of the therapists in the study received regular supervision (Strupp and Hadley, 1979). Given that supervision is an experiential learning process (e.g. Jennings, 1996), arguably, therapists without post-graduate therapeutic training, through supervision, had their training extended, which would have influenced their outcomes.

An alternate explanation for the study findings however is that the supposed comparison between training levels of the practitioners was obscured by the fact that a number of the participants in each group had not in fact completed their training and were trainees. In addition, a number of participants in both groups had engaged in further training, such as supervision training. As discussed in the method section, the aim in this study was to create
a more complex ‘training’ variable than had been utilised in prior research, however
collecting more data on the practitioners in this study underscored how complex it is to
make judgements about whether practitioners were more or less trained than each other.
Further, in the context of a naturalistic NHS setting in which staff are supported in acquiring
further training and the work force also includes trainees currently enrolled on training
programmes, it is likely that simplistic distinctions related to training may necessarily be
difficult to make. It should be noted also that the difficulty in this study in creating a ‘clean’
training variable suggests that the results of this study should be treated with caution; it
may be the fact that higher levels of training are influential in creating higher client
outcomes but that the design of this study prevented this from being evident.

However, in addition to the study limitation in terms of group definition, the study is also
limited by the sample size. Despite a five-year search of the Trust archives there were only
just over a hundred clients in this study; given the observed mean differences it is possible
that with a higher N, and thus greater power, a statistically significant difference might have
been found. A significantly larger sample size would also have made it possible to use multi-
level modelling approaches instead of the ANCOVAs utilised in the current study. ANCOVAs
were used because they are appropriate for a sample size such as that in the current study;
in addition much of the prior research in this area has used ANCOVAs (e.g. Antonuccio, et
al., 1987; Vocisano, et al., 2004). That said, therapist/client data is ‘nested’ which means
that it violates assumptions about the independence of the key outcome variable (here
client post-therapy scores) in that the clients of a particular therapist logically are likely to
have more similar results. This fact means that increasingly, where the sample size allows,
multi-level models are recommended (e.g. Hox, 2010).
Future investigations would benefit first of all from systematic attempts to create clearly different training groups. Given the difficulties evident in this study, a larger sample of both clients and therapists might make this easier. For example, it might be possible to separate out trainees from full qualified as well as to separate training in terms of length as well as qualification level (undergraduate, masters, doctoral). In addition, larger therapist samples and a greater number of clients per therapist as this would allow more powerful statistical techniques such as multi-level modelling (e.g. Hox, 2010) to be used.

**Implications for Practice and Training**

This paper has presented a study which found a non-significant association between more advanced training and client outcomes, something which has clear implications for both practice and training however, various readings of the study results have also been presented- including that the study results are an artefact of issues with the study design or sample size. A critical discussion of the methodology of this type of study is important for the field because of the significance for the discipline area of this topic. Professional organisations such as the BACP, UKCP, HCPC and BPS Clinical and Counselling Psychology Division set out highly detailed training standards and are involved in laborious accreditations of trainings on the basis that having a well trained workforce helps towards achieving and maintaining good standards of practice (BACP 2010). In the workforce higher levels of training are potentially associated with higher levels of pay as well as higher levels of responsibility so the assumptions about the importance of training are critical for individuals also. This means that while there has been a dearth of recent research examining connections between training and client outcome, this is still a significant area of research
for practitioners. The current paper, with all its potential methodological issues, is in this context a valuable addition to the field.
### Tables

Table 1 *Table showing the therapists training for each of the items that makes up the high and low training groups*

<table>
<thead>
<tr>
<th></th>
<th>Level of training</th>
<th>Years of training</th>
<th>Supervision training</th>
<th>Additional specialist training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High training</strong> (N=4)</td>
<td>Post graduate degree</td>
<td>0-6 years</td>
<td>1=yes, 3=no</td>
<td>2=yes, 2=no</td>
</tr>
<tr>
<td><strong>Low training</strong> (N=5)</td>
<td>Diploma-Degree</td>
<td>0-3 years</td>
<td>2=yes, 3=no</td>
<td>4=yes, 1=no</td>
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</tbody>
</table>
Table 2 *Descriptive statistics for pre-and post-therapy CORE scales*

<table>
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<tr>
<th></th>
<th>Skewness</th>
<th></th>
<th>Kurtosis</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Statistic</td>
<td>Std. Error</td>
<td>Statistic</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Well being</td>
<td>9.290</td>
<td>.237</td>
<td>91.843</td>
<td>.469</td>
</tr>
<tr>
<td>Problems</td>
<td>-.283</td>
<td>.237</td>
<td>-.462</td>
<td>.469</td>
</tr>
<tr>
<td>Functioning</td>
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<td>.237</td>
<td>-.236</td>
<td>.469</td>
</tr>
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<td>Risk</td>
<td>.722</td>
<td>.237</td>
<td>-.012</td>
<td>.469</td>
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</table>
Table 3: CORE total and sub-scale scores for the High and Low therapists training groups

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<tr>
<th>Groups</th>
<th>Well being</th>
<th>Problems</th>
<th>Functioning</th>
<th>Risk</th>
<th>Total CORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low training</strong></td>
<td>Mean</td>
<td>7.76</td>
<td>24.27</td>
<td>19.73</td>
<td>54.51</td>
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<tr>
<td><strong>high training</strong></td>
<td>Mean</td>
<td>7.04</td>
<td>22.29</td>
<td>17.56</td>
<td>48.78</td>
</tr>
<tr>
<td></td>
<td>Std. Deviation</td>
<td>4.134</td>
<td>11.377</td>
<td>9.910</td>
<td>27.61</td>
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</table>
Table 4 *Outcomes of the ANCOVA for CORE Total and sub-scales for the two therapist training groups*

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<th>Mean (SD)</th>
<th>df</th>
<th>F value</th>
<th>Significance</th>
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<tr>
<td>Well being</td>
<td>7.45 (4.21)</td>
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<td>.794</td>
<td>375</td>
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<tr>
<td>Problems</td>
<td>23.41 (12.5)</td>
<td>1,101</td>
<td>.280</td>
<td>.598</td>
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<tr>
<td>Functioning</td>
<td>18.79 (9.92)</td>
<td>1,101</td>
<td>1.262</td>
<td>.264</td>
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<tr>
<td>Risk</td>
<td>2.95 (4.86)</td>
<td>1,101</td>
<td>.600</td>
<td>.441</td>
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</tbody>
</table>
Figures

Figure 3.1 Clients level of distress at the start of therapy
Figure 3.2 The number of therapy sessions completed by clients
Figure 3.3 The number of clients per therapist
Figure 3.4 A flow chart illustrating the selection and preparation process of the data ready for the statistical analyses
Figure 4.3 A histogram showing the distribution of the pre CORE scores excluding the scores below 34 points
References


The journal targeted for the submission of this article was Psychology and Psychotherapy: Theory, Research and Practice. This journal was selected for three main reasons. First, it has a strong focus on therapeutic outcome studies. Secondly, it is a British journal but also has a worldwide audience. Finally, it is a highly used journal within this area of research.

Overview of guidelines:

- Word limit is 5000 excluding abstract, references, figures and tables
- Articles must be typed in double spacing and all pages must be numbered
- A template front cover page must be used
- Tables should be double spaced with title and each to be placed on a separate page at the end of the article
- Figures should be placed at the end of the document
- The article should include a structured abstract of up to 250 words and should include the headings: objectives, design, method, results and conclusions
- All articles must include 2-4 practitioner points in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly outline the relevance of the research to professional practice
- APA reference style must be used
- Authors are requested to avoid sexist language
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc. For which they do not own copyright.
Appendix 1
### Over the last week

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Only Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most of the Time</th>
<th>Except yesterday</th>
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</thead>
<tbody>
<tr>
<td>1. I have felt terribly alone and isolated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I have felt tense, anxious or nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I have felt I have someone to turn to for support when needed</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. I have felt O.K. about myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I have felt totally lacking in energy and enthusiasm</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6. I have been physically violent to others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I have felt able to cope when things go wrong</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I have been troubled by aches, pains or other physical problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I have thought of hurting myself</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Talking to people has felt too much for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Tension and anxiety have prevented me doing important things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I have been happy with the things I have done.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I have been disturbed by unwanted thoughts and feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I have felt like crying</td>
<td></td>
<td></td>
<td></td>
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</table>

**Please turn over**
## Over the last week

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<th>Number</th>
<th>Description</th>
<th>Scale</th>
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<tbody>
<tr>
<td>15</td>
<td>I have felt panic or terror</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I made plans to end my life</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I have felt overwhelmed by my problems</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I have had difficulty getting to sleep or staying asleep</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>I have felt warmth or affection for someone</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>My problems have been impossible to put to one side</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>I have been able to do most things I needed to</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I have threatened or intimidated another person</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I have felt despairing or hopeless</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>I have thought it would be better if I were dead</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I have felt criticised by other people</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>I have thought I have no friends</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>I have felt unhappy</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Unwanted images or memories have been distressing me</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>I have been irritable when with other people</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>I have thought I am to blame for my problems and difficulties</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>I have felt optimistic about my future</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>I have achieved the things I wanted to</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>I have felt humiliated or shamed by other people</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>I have hurt myself physically or taken dangerous risks with my health</td>
<td></td>
</tr>
</tbody>
</table>

### Mean Scores

<table>
<thead>
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<tr>
<td>(F)</td>
<td></td>
<td></td>
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<tr>
<td>(R)</td>
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<td></td>
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<tr>
<td>All Items</td>
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<tr>
<td>All minus R</td>
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</table>

**THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE**

Survey: 151  Copyright MHF and CORE System Group.
Appendix 2
### Box 2: Look-up table of CORE-OM scores and severity levels

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<th>Non-clinical range</th>
<th>Clinical range</th>
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<td>3</td>
<td>0.9</td>
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<tr>
<td>4</td>
<td>1.2</td>
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<tr>
<td>5</td>
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<td>4</td>
</tr>
<tr>
<td>6</td>
<td>1.8</td>
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<tr>
<td>8</td>
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**Guidance notes**

1. The original mean item score can be readily calculated by dividing the clinical score by 10.
2. The ‘simple’ score uses the first integer only of the clinical score as a rough guide.
3. The reliable change index is 5 points and the cut-off level is a clinical score of 10 (or .5 and 1 respectively if using the traditional scoring method).
Appendix 3
ABMU MH Directorate Census

Psychiatrists, Psychologists and Psychological Therapists Providing Psychological Therapy

February 2012

Name: ________________________________

Email: ___

Team Setting: __________________________

Job Title: _____________

Year Qualified: Registration Organisation(s): _______

If currently in training as a ‘psychologist’ expected year of Q:_______

No of hours worked: Contract: Permanent Temp □ v Honorary □

No of hours offering psychological therapy per week: □

If not formally trained (i.e. knowledge and skills 'gained on the job') how long have you been providing psychological therapies ______ years
If dual qualified – your other qualification/title: __________________________

Main therapeutic orientation: __________________________

Languages (other than English) offered: ______________________

<table>
<thead>
<tr>
<th>Therapies Offered:</th>
<th>Therapeutic Group Work Offered:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
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</table>

Please tick if you are specifically trained in:

CBT for Eating Disorders          DBT  EMDR  Trauma focused CBT

CBT for Psychosis                      Psychological Therapy in Welsh medium

Early Intervention for psychosis  (please state model____________________)
<table>
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<th>Setting Where Therapies Delivered:</th>
<th>Hours Worked:</th>
<th>How Often:</th>
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**Formal Psychological Therapy Training:**

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<th>Duration:</th>
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**Psychological Skills Training (short/day courses) past 10 years:**

<table>
<thead>
<tr>
<th>Name Of Course:</th>
<th>Institution:</th>
<th>Level:</th>
<th>Duration:</th>
<th>Year:</th>
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</thead>
<tbody>
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(Please attach additional sheet if required).

Planned Future Trainings:

<table>
<thead>
<tr>
<th>Name Of Course:</th>
<th>Institution:</th>
<th>Level:</th>
<th>Duration</th>
<th>Year:</th>
<th>Approved (y or n):</th>
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Supervision

Supervision Training:

<table>
<thead>
<tr>
<th>Name Of Course</th>
<th>Provider</th>
<th>Model</th>
<th>Length Of Course</th>
<th>Date</th>
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</table>
Supervision Provided:

<table>
<thead>
<tr>
<th>Name of Supervisee</th>
<th>Profession/title</th>
<th>How Often</th>
<th>Modality (group/individual)</th>
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</table>

Please list areas of expertise for which you are qualified to offer supervision and CPD/in house training.

<table>
<thead>
<tr>
<th>Supervision expertise</th>
<th>Training expertise</th>
</tr>
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</table>

Are you actually able to offer this expertise?

- [ ] Yes  
- [ ] No

If “no” state reason(s):

______________________________________________________________
Supervision received:

<table>
<thead>
<tr>
<th>From Whom</th>
<th>Profession</th>
<th>How Often</th>
<th>Modality (group/indiv)</th>
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</table>

Do you have any unmet supervision needs: Yes [ ] No [ ]

Supervision required for:

<table>
<thead>
<tr>
<th>Supervision required for:</th>
<th>By whom/type of supervisor:</th>
<th>How often:</th>
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<tbody>
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</table>

Are there any therapies/interventions in which you are competent yet unable to offer?

Yes [ ] No [ ]

If yes please specify and explain reasons why not able to offer:
### Capacity to deliver psychological therapies and other related interventions:

<table>
<thead>
<tr>
<th>Intervention/therapy</th>
<th>Percentage of time spent per month:</th>
<th>Percentage of time (total 100%)</th>
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</thead>
<tbody>
<tr>
<td>Psychological therapy 1:1</td>
<td></td>
<td>%</td>
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<tr>
<td>Group therapy</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Psycho-education groups</td>
<td></td>
<td>%</td>
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<tr>
<td>Admin (general)</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Admin (client related – reports etc)</td>
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<td>%</td>
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<tr>
<td>CPD/Training</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Supervision (received)</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Supervision (delivered)</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
<td>%</td>
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<tr>
<td>Other</td>
<td></td>
<td>%</td>
</tr>
</tbody>
</table>

Please specify percentage of time spent in the following:
Caseload information

Waiting Times:

<table>
<thead>
<tr>
<th>Do you hold your own waiting list?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If yes – do you assess on access?)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes please also indicate:

<table>
<thead>
<tr>
<th>Waiting for: (type of intervention)</th>
<th>How many currently waiting</th>
<th>How long waiting (date of referral to you):</th>
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Current caseload (as of 31st December 2011):

<table>
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<tr>
<th>Intervention type:</th>
<th>Total no on current caseload:</th>
<th>No of sessions to date:</th>
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</table>

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If you routinely use *outcome measures/satisfaction questionnaires* to evaluate your practice please specify which:

<table>
<thead>
<tr>
<th>Name and type of measure</th>
<th>Routinely (R) / Occasionally (O)</th>
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<tbody>
<tr>
<td>CORE</td>
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<td>HADS</td>
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<td>BDI</td>
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<td>BAI</td>
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<tr>
<td>Dept. Satisfaction q’aire</td>
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</table>

**General Issues:**

Any issues or suggestions that you wish to be included in this current review of Psychological Therapies (e.g. ideas for improving the psychological therapy service/resource in ABMU Mental Health Directorate):

More clearly defined and disseminated service inclusion/exclusion criteria. There are an increasing number of referrals for specialist areas and/or mental health difficulties are not the primary presenting issues, for example, forensic, pain, and Asperger’s syndrome.
Specialist interests:

Please list any current specialist areas of interest:


Please list any planned/developing specialist areas of interest:


Thank you for your co-operation in this review – the results of which once analysed will be disseminated via the Psychological Therapies Management Committee (PTMC) and utilised for service development and resource planning.

Please return by the 24th February 2012 to A. Eccles

(Assistant Psychologist)

Tel: 01792 517025
Appendix 4
Dear Mandy

RESEARCH DEGREE REGISTRATION: TITLE – Therapist effects on the outcome of psychological therapy in an NHS setting: experience, training and attachment styles.

I am pleased to inform you that the Faculty’s Research Degrees Committee has approved your application for your Research Project as part of your part time Professional Doctorate registration.

An electronic copy of the handbook for research students as well as the most up-to-date regulations and other useful information for your studies can be found on the following website: http://www1.uwe.ac.uk/research/postgraduateresearchstudent.aspx

Please feel free to get in touch with me if there are any matters on which you require more clarification.

Yours sincerely

Carolyn Morgan
Graduate School Officer
graduateschool@uwe.ac.uk
Tel: 0117 326 8569

cc: Dr Fiona Cramp (Director of Postgraduate Research Studies)  
   Dr Naomi Moller  
   Dr Paul Redford
Hi

If you use staff data you do not need to go through ethics, this is dealt with just by R&D now. Not sure what an audit type research project is, one or the other? I attach a leaflet to help you decide which it could be. If you did adopt the existing client questionnaire data as a research project, under the recent changes to the remit of Ethics Committees:-

REC review is required for research involving use of previously collected information from which patients could be identified by researchers outside the usual care team.

BUT

REC review is not required for research limited to use of previously collected non-identifiable information. This exception also applies to research undertaken by staff within a care team using information previously collected in the course of care for their own patients provided that data is anonymised in conducting the research. Such research would involve no breach of the duty of confidentiality owed by care professionals.

Therefore, anonymity is the key as above. However, if you wish to add a research question of your own I don’t understand how this would work as you would be using previously collected data and then tagging on a question. Does this mean you would just be asking your one research question to the same group of clients and adding the responses to the existing obtained data. If this is the case you would be in a situation where potentially the existing data would not require ethical review but the new ‘questionnaire’ would be required to go through the ethics process.

With regard to your last query other than the attached leaflet I am not aware of any guidance of potential research you could do in the timeframe you have. I would have thought your supervisor was the person to advise you on this!

If you have any further queries or if I can help in any other way please let me know.

Best wishes

Sue
Hi Mandy

Please accept this email as confirmation that your project does not need R&D approval. Should you need further clarification please do not hesitate to contact me. I understand that Dyfed-Powys have already confirmed that you do not need ethical approval.

Kind regards

Cynthia

Cynthia Davis
Asst R&D Manager
Abertawe Bro Morgannwg University Health Board
Morriston Hospital
Swansea
SA6 6NL

T: 01792 704056 FREE  Morriston

T: 01656 752477 FREE  Princess of Wales

F: 01792 545774
Appendix 6
PRIVATE & CONFIDENTIAL

11th May 2010

To whom it may concern,

RE: Research proposal by Mandy Newman, trainee counselling psychologist.

Upon the approval of the NHS ethics committee, I am happy for Mandy to undertake her research within the psychology department.

Yours sincerely

Amanda Hall
Consultant Psychologist
Appendix 7
CLIENT CONSENT FORM

I have read the information sheet provided and I agree to the fair and lawful processing of personal information for the purposes of analysis and research in line with the Data Protection Act 1998.

I understand that the CORE researchers based at the Psychological Therapies Research Centre, University of Leeds, will not have access to any personal data provided (e.g. name, address, date of birth) which makes the information identifiable to me and that I will not be identified in any way in anything that is written or reported about the research.

Signature

.................................................................

Name (block capitals)

.................................................................

Date

.................................................................