Counselling and Psychotherapy Research, 2013
Vol. 13, No. 4, 246–253, http://dx.doi.org/10.1080/14733145.2012.761258

Routledge
Taylor & Francis Group

ORIGINAL ARTICLE

Clients' experience of therapy and its outcomes in 'good' and 'poor' outcome psychological therapy in a primary care setting: An exploratory study

JAMES MCELVANEY* & LADISLAV TIMULAK

School of Psychology, Trinity College Dublin, Dublin, Ireland

Abstract
Aim: The qualitative experience of clients judged by quantitative measures as having 'good' or 'poor' outcome is not often the focus of outcome research. This exploratory study investigates client experience of psychological therapy in an inner-city primary care centre across two client groups, differentiated on the basis of their outcome scores on quantitative measures. *Method:* Clients ($N = 11$) were allocated to one of two research groups, (a) good outcome ($n = 5$), or (b) poor outcome ($n = 6$) on the basis of their pre- and post-therapy outcome scores on the Clinical Outcome in Routine Evaluation-Outcome Measure (CORE-OM). They participated in a face-to-face semi-structured interview. Data were recorded and analysed using a descriptive and interpretive qualitative method. *Results:* Both groups had broadly similar experiences of their current therapy although some differences in emphasis emerged. Good outcome clients described a greater sense of empowerment in therapy, commenting on a feeling of equality with their therapist and exhibiting greater autonomy overall. Poor outcome clients valued therapist support and while reporting increased awareness of problematic functioning described a reluctance to engage fully in the therapeutic process. *Conclusion:* There was very little difference in the qualitative accounts of therapy and its impact by the clients deemed by quantitative pre-post therapy measurement as either 'good outcome' or 'poor outcome'. There is further research warranted, examining whether clients that seem to benefit from therapy according to standard pre-post measurement, experience therapy and its impact differently to clients whose pre-post results suggest that therapy did not work.

Keywords: psychotherapy; process; outcome; primary care

Introduction

Despite the growing trend towards mixed methods research in psychotherapy, not much is known about the relationship between quantitative and qualitative evaluation of psychological therapy (Timulak & Creaner, 2010). Few existing studies have looked at clients' 'qualitative' experiences of therapy and its outcomes, while also considering whether the client's status, as measured by traditional quantitative means, can be judged to have either 'recovered/improved' or 'not changed/deteriorated'. Some suggest that it may be difficult to see any differences in subjective experience between clients judged by quantitative measures as having good or poor outcomes (Klein & Elliott, 2006). This study aims to contribute to this knowledge by examining whether or not there are any qualitative differences between two groups of clients. One group is described as 'quantitatively recovered/improved' while the other is 'not changed/deteriorated', as measured by pre-post difference on a standardised measure. We specifically examined 'qualitative' experiences of helpful and hindering aspects/impacts of therapy sessions and overall (outside the sessions) therapy outcome across these two groups.

Traditionally, studies investigating hindering or helpful aspects of therapy have not attempted to

*Corresponding author. Email: mcelvaj@tcd.ie

distinguish between the experiences of 'good outcome' and 'poor outcome' clients. Studies have reported on clients' experiences regardless of the outcome of their therapy (Gershefski, Arnkoff, Glass, & Elkin, 1996; Levitt, Butler, & Hill, 2006; Levy, Glass, Arnkoff, & Gershefski, 1996; Lietaer, 1992; Lietaer & Neirinc, 1986; Paulson, Everall, & Stuart, 2001; Paulson, Truscott, & Stuart, 1999; Paulson & Worth, 2002). Occasionally however, they have differentiated between the clients' experiences in different forms of therapy: e.g. cognitive vs. interpersonal (Gershefski et al., 1996; Levy et al., 1996). Methodologically these studies rely on retrospective accounts, i.e. 'after session' or 'after end-of-therapy' questionnaires or interviews.

A considerable amount is now known regarding the findings of helpful and hindering aspects of therapy studies. For instance, Paulson and colleagues (1999) found that clients regarded the following as helpful: a particular therapist's style (e.g. being attentive), some therapists' interventions (e.g. providing clarification), generation of client resources, new perspectives, emotional relief, client self-disclosure, gaining knowledge, accessibility of counselling, client resolution of problems. A follow-up study (Paulson et al., 2001) looking at unhelpful aspects reported by clients found that clients expressed concerns about vulnerability, lack of commitment/motivation, uncertain expectations, lack of connection, barriers to feeling understood, structure of counselling (e.g. session irregularity), negative counsellor behaviours, insufficient counsellor directiveness and lack of responsiveness.

It is only relatively recently that the first qualitative psychotherapy outcome studies have begun to appear (McLeod, 2001). These studies invite clients to describe in their own words what has changed for better or worse in their lives due to therapy. Early meta-analytic summaries of the qualitative outcomes of predominantly humanistic therapies report the following categories of changes: Leaving Distress Behind, Increased Contact with Emotional Self, Improved Self-Esteem, Increased Sense of Personal Power, Defining Self with Others, Engaging with Others, Healthier Emotional Experiencing, Self-Insight and Self-Awareness, Experience of Self-Compassion, Enjoying Interpersonal Encounters, Mastery of Symptoms, Appreciating Vulnerability, etc. (Timulak & Creaner, 2010). Little is known about the relationship between the reported qualitative outcomes and the outcomes based on the clients filling standardised measures pre- and post-therapy. Examination of the few studies which have scrutinised this relationship suggests that it may prove difficult to find any differences in reports of qualitative outcomes between clients defined as good and poor outcome clients' on quantitative measures (Klein & Elliott, 2006). This may not, however, be the case in extremely good outcome and extremely poor outcome cases (Lipkin, 1948).

This study aims to examine both the clients' experiences of therapy as well as their reported outcomes. Our aim was to collect those experiences through qualitative means, thereby giving a voice to clients. However, we also wanted to examine whether subgroups of clients divided by outcomes on traditional quantitative instruments employed in measuring therapy outcome, i.e. self-report measures utilised pre- and post-therapy, had differing experiences of therapy and its outcome. We were unable to locate any study that examined this type of problem. The nearest study was Nilsson, Svensson, Sandell, and Clinton's (2007) paper which looked at qualitative experiences of therapy and its outcomes among four groups of clients, differentiated retrospectively, on the basis of a qualitative interview. The groups comprised those who underwent cognitive-behavioural therapy (CBT) and were unsatisfied with it (this judgement was based on a qualitative interview), those who underwent CBT and were satisfied with it, those who underwent psychodynamic therapy (PDT) and were unsatisfied with it and finally those who underwent PDT and were satisfied with it.

Nilsson et al.'s (2007) study looked at the differences in experiences and reported changes among the clients who retrospectively, were not happy with their therapy. However, as we said above, not much is known about client experiences in light of their being assessed quantitatively (on the basis of pre-post difference on a standardised measure) as being good outcome (recovered or reliably changed) vs. poor outcome (not changed or deteriorated). We therefore elected to conduct our examination from this perspective, focusing specifically on the experience of: outcomes of therapy, helpful aspects of therapy, hindering aspects of therapy, and therapist and therapeutic relationship. We chose a primary care setting for soliciting participants because it is quite representative of the diversity of issues for which counselling is considered a good option of support. Furthermore, while it is recognised that counselling in primary care settings is worth studying, and the number of studies in this area are

growing, the studies primarily focus on the effectiveness of therapy measured by outcomes measured by quantitative means (Brettle, Hill, & Jenkins, 2008) without accounting for the extent to which this corresponds with the clients' experience in their own words.

Method

Participants

Eleven clients at an inner-city primary care centre participated in this research. Six of the clients were male and five were female; all were Caucasian, Irish nationals. Their ages ranged from 24–67 years with a mean age of 48. All of the clients lived in the catchment area for the primary care centre. All participated voluntarily in the research. Prior to being invited to participate they participated in brief counselling, consisting of 6–8 sessions. The therapists comprised a female senior counselling psychologist for the primary care team (who saw eight of the clients) and a male counselling psychology trainee (who saw three); both therapists shared a theoretical orientation incorporating CBT and person-centred approaches.

Measures

Client outcome in routine evaluation-outcome measure (CORE-OM). The CORE-OM is a 34- item questionnaire designed to measure a 'pan-theoretical core of clients' global distress' which is then expressed as an average score and can be used pre- and post-therapy to evaluate (clinical) change (Core Systems Group, 1998, p. 85). CORE-OM is used in primary care settings as it is brief, can be scored by hand and is acceptable to therapists and clients (Evans et al., 2000). Research suggests that it is reliable and valid across multiple settings, and can provide information on the level of severity of client presentations in the context of outcome benchmarks which employ the concepts of reliability and clinically significant change (Barkhamet al., 2001).

The semi-structured interview. The semi-structured interview used in the study was informed in terms of both structure and content by Elliott's (2000) *Client Change Interview Protocol*. The interview was refined after one pilot interview where the researcher discarded two questions, which solicited the client's opinions on technical aspects of the service rather than focussing on their experience of therapy. The questions asked included: *Can you sum up what was helpful/unhelpful in your therapy? Were there some things that were difficult or painful but still OK or helpful? Was there anything missing from your experience of counselling? How would you describe your relationship with the therapist? Were there any changes that you noticed in yourself since starting the counselling? How has attending counselling affected your ability to cope with difficult life issues?* All of the interviews were recorded and transcribed.

Procedure

The first author analysed the pre-post CORE-OM data of 17 clients that satisfied the inclusion criteria: they had attended the service within the last six months, had not participated in any other research related to the service and had attended for a minimum of six weeks, completing CORE-OM forms on their first and last sessions. The pre-post CORE data were gathered as a part of routine assessment used by the service and were administered by the therapists in the study. Two clients no longer lived in the catchment area for the service and four others were unwilling to take part. The clients were divided into two groups: those who, after completing therapy, improved or recovered using the Reliable Change Index and clinical Cut-off as indicators were described as *good outcome* and those who stayed the same or deteriorated were described as *poor outcome*.

Having secured verbal consent from 11 clients to proceed, the researcher posted each a package containing an information sheet and a consent form. Clients were informed that upon receiving their returned form, the researcher would contact them to arrange the face-to-face interview. See Table I for the client's pre-post outcome evaluation.

Interviews were set up and conducted at times of the clients' choosing in an interview room at the centre and took between 20 and 30 minutes to conduct. Prior to commencing the interview a brief (approximately three minutes) unscripted mindfulness exercise was carried out which encouraged clients to reflect on the thoughts, feelings and emotions which accompanied their experience of attending therapy at the service. Interviews were then taped and upon completion, clients were presented with a debriefing sheet which thanked them for their participation and offered contact numbers if they felt they had been adversely affected by the experience and needed further assistance.

Table I. Results of client pre-post- outcome evaluation.

Client	Pre-CORE-OM score	Post-CORE-OM score	Status[b]
Client B	1.70 (C)[a]	0.80 (NC)	Recovered
Client D	2.58 (C)	0.75 (NC)	Recovered
Client I	2.64 (C)	1.80 (C)	Improved
Client J	1.26 (NC)	0.32 (NC)	Improved
Client H	1.71 (C)	1.29 (C)	Improved
Client F	3.24(C)	1.92 (C)	Improved
Client K	1.11 (NC)	1.23 (C)	No Change
Client G	1.67 (C)	1.80 (C)	No Change
Client C	1.82 (C)	1.64 (C)	No Change
Client A	1.0 (NC)	1.88 (C)	Deteriorated
Client E	0.41 (NC)	1.76 (C)	Deteriorated

[a]C, Clinical; NC, Non-Clinical.
[b]Barkham et al. (2001) recommend a clinical significance cut-off value of 1.19 for males and 1.29 for females with values above cut-off likely to represent clinical population. Barkham et al. (2001) put the reliable change index interval at 0.48.
Recovered clients exhibit statistically reliable change and move from the clinical to the non-clinical range.
Improved clients exhibit statistically reliable change but do not move from the clinical to the non-clinical range (with the exception of Client J who improved within the non-clinical range).
No Change clients do not exhibit statistically reliable change.
Deteriorated clients exhibit statistically reliable change moving into, or further into the clinical range.

The first author then immediately transcribed the interview.

Data analysis

Data analysis was carried out using a descriptive and interpretive qualitative research method described by Elliott and Timulak (Elliott & Timulak, 2005). The approach is systematic yet flexible and easily lends itself towards checking and auditing through 'careful archiving' of all stages of the analytic process (p. 152). All interviews were read in their entirety so that the first author could get a feel for the data. At this point 'obvious redundancies, repetitions, and unimportant digressions' were removed from the data (p. 152). Data were then divided into distinct *meaning units* each of which could convey a specific meaning to a reader even if viewed out of context. Meaning units were coded according to which client produced them and the temporal sequence in which they occurred, enabling the auditor (the second author) to follow a clear *audit trail* at any later point in the analysis if required.

Domains that structured the responses from the clients were then outlined. They were suggested by the literature review and the questions on the semi-structured interview, but were not finalised until the data brought by the clients were analysed. They covered (a) helpful and (b) unhelpful aspects of therapy. They also covered (c) experiences of therapeutic relationship, and (d) experiences of change attributed to therapy. Meaning units were then assorted to the relevant domains. Within the domains they were assessed as to their similarity and clustered on the basis of containing the same or similar meanings. Categories of meaning units, i.e. participants' reports, were thus created within each of the domains. Categories were formed based on the content of the meaning units provided by the clients. The categorisation is a subjective, interactive process whereby the researcher attempts to organise the data in a manner congruent with the clients' meaning and expression, while acknowledging a potential impact of his or her own theoretical knowledge. Categories were not mutually exclusive, which means that a specific meaning unit could be assigned to more than one category if it contained more than one relevant meaning.

The analysis was performed by the first author (a counselling psychology trainee of predominantly humanistic orientation) and then thoroughly audited by the second author (experienced counselling psychologist and researcher of the same orientation). The auditor did not know whether the accounts belonged to the 'good outcome' or 'poor outcome' group. The final wording and delineation of categories was then agreed on by consensus. Both researchers anticipated at the outset of the research that, despite limited evidence in the existing research, it was reasonable to expect that there would be meaningful differences between the two groups when quantitatively measured as having good and poor outcome. We expected that the 'good' outcome group will report more positive outcomes and will also point to noticeably more helpful aspects of therapy.

Ethics

Prior to conducting the study, ethical approval was sought from and granted by both the local health service and the University Ethics Committee. All data were kept following data protection policy which was informed by the relevant Data Protection Acts. Participants could withdraw at any point during the study without prejudice and gave informed consent for their participation.

Results

The clients' reported helpful aspects/impacts of therapy were clustered into five categories that are presented in Table II. Two categories: *Heightened Awareness of Problematic Functioning* and *Mastery of Problematic Experience* were more typical for the clients that did not benefit from therapy as judged by CORE-OM outcomes. An example of *Heightened Awareness of Problematic Functioning* may be illustrated by a quote from one of the 'poor outcome' clients: *Because if you just keep blocking out what's coming into your head straight off, it's not always the right thing. And a lot of the time it can be eh, a defensive thing where it's not needed*. The next three helpful aspects/impacts of therapy categories referred to experiences of feeling supported while in therapy (*Beneficial Support* category), experiences of appreciating information included in psycho-educational materials used in therapy (*Found Psych-ed/practical material helpful*) and finally to experiences of feeling more calm and/or relaxed when in the session (*Feeling Calm/Relaxed*). Given the small numbers of participants it is difficult to determine whether the occurrence between 'good outcome' and 'poor outcome' clients differed.

Unhelpful in-session aspects/impacts of therapy were reported to a somewhat lesser degree (for the overview see Table III). Interestingly four out of six 'good outcome' clients reported *Feeling Exposed* as an unhelpful aspect of therapy, while none of the 'poor outcome' clients reported this. The following quote serves to illustrate this category: *It takes a lot out of me, exposing yourself, letting people see the good and bad side of you*. Other reported unhelpful aspects/impacts were occasionally reported. These included *Limited Access* to the therapist, *Doubts About Appropriateness of Counselling*, *Still Felt as Bad After Therapy*, *Not Understanding Psycho-Educational Material* and *Psycho-ed Material Incomprehensible*. A clear pattern, suggesting that a particular experience might be more typical for one or the other group, did not emerge.

Regarding the clients' experience of their relationship with the therapist, interestingly 'poor outcome' clients reported more often that they *Valued Therapists Guidance*, while 'good outcome' clients reported more often that they *Valued Therapist's Equality* (see Table IV). An example of the category *Valued Therapist's Guidance* is the following quote:

> Ehm . . . When I see [therapist's name] now I find that she's able to point out that it's not all [husband's name]. It's me as well. Parts that I didn't see for myself, do you know. An example of the category Valued Therapist's Equality would be

Table II. Helpful in-session aspects/impacts of therapy.

Helpful in-session aspects/impacts of therapy	Good outcome clients	Poor outcome clients
(i) Heightened awareness of problematic functioning	1/6	5/5
(ii) Mastery of problematic experience	1/6	4/5
(iii) Beneficial support	6/6	4/5
(iv) Found Psych-ed/practical material helpful	3/6	2/5
(v) Feeling more calm/relaxed	3/6	1/5

Note: Group A had six members, hence the number of clients fitting into any one category is represented as x/6. Correspondingly Group B had five members and scores are represented as x/5.

Table III. Unhelpful in-session aspects/impacts of therapy.

Unhelpful aspects/impacts	Good outcome clients	Poor outcome clients
(i) Felt exposed by therapist	2/6	0/5
(ii) Had limited access to therapist	1/6	2/5
(iii) Doubts about appropriateness	0/6	1/5
(iv) Still felt bad after therapy	1/6	0/5
(v) Difficulty discussing family issues	2/6	0/5
(vi) Difficulty discussing recent trauma	2/6	0/5
(vii) Not understanding pyscho-educational material	0/6	1/5

Note: Group A had six members, hence the number of clients fitting into any one category is represented as x/6. Correspondingly Group B had five members and scores are represented as x/5.

Table IV. Clients perception of relationship with therapist.

Perception of relationship	Good outcome clients	Poor outcome clients
(i) Valued therapist's guidance	0/6	3/5
(ii) Valued therapist's equality	4/6	1/5
(iii) Valued therapist's professional competence	3/6	1/5
(iv) Valued therapist's non-judgemental stance	1/6	1/5

Note: Group A had six members, hence the number of clients fitting into any one category is represented as x/6. Correspondingly Group B had five members and scores are represented as x/5.

following quote: Ehm, well she was very good, she was . . . I like the fact that you're telling her things, like, that are personal to you and instead of her just listening, and taking notes down or whatever [. . .] so she feels like a friend and a person who relates to what you're talking about . . . .

The difference between 'good outcome' and 'poor outcome' clients was less obvious for the other two reported types of experiences of the relationship with the therapist. These captured the clients' accounts in which they *Valued Therapist's Professional Competence* (though in this case it seems that it was slightly more typical for the 'good outcome' group) and in which they *Valued Therapist's Non-judgemental Stance*.

A somewhat less clear picture is offered by the Experience of Change due to Therapy domain, i.e. qualitative outcomes of therapy. Of the seven categories (see Table V): *Improved Emotional Functioning*, *Improved Interpersonal Relationships*, *Increased Sense of Personal Power*, *Increased Acceptance of Role in Life: Responsibility*, *Greater Self-Acceptance*, *Improved Coping Strategies*, *Greater Self-Awareness*; only three suggested some differences. The two pointing at increased (self) acceptance (*Increased Acceptance of Role in Life: Responsibility* and *Greater Self-Acceptance*) were more typical for 'good outcome' clients, while *Greater Self-Awareness* (often of problematic functioning) was more present among the 'poor outcome' clients. The following quote illustrates the category *Improved Emotional Functioning*:

Table V. Experience of change due to therapy.

Experience of change		Good outcome clients	Poor outcome clients
(i)	Improved emotional functioning	3/6	3/5
(ii)	Improved interpersonal relationships	2/6	1/5
(iii)	Increased sense of personal power	3/6	3/5
(iv)	Increased acceptance of role in life: Responsibility	5/6	3/5
(v)	Greater self-acceptance	3/6	1/5
(vi)	Improved coping strategies	3/6	2/5
(vii)	Greater self-awareness	1/6	4/5

Note: Group A had six members, hence the number of clients fitting into any one category is represented as x/6. Correspondingly Group B had five members and scores are represented as x/5.

I'm much more calmer. Much more calmer. And I find I can talk about my problems without getting really upset, because I was never a person who cried an awful lot but, when I had the problems I was getting that the least thing would set me off.

Discussion

Our findings exhibited a degree of overlap with previous studies on helpful and hindering aspects of therapy. For instance, the helpful impact of increased awareness has been reported in several studies (Feifel & Eells, 1963; Gershefski et al., 1996), as were experiences of mastery of problematic experience (Gershefski et al., 1996), and feelings of calmness and relaxation (Paulson et al., 1999).With regard to hindering aspects, again the findings are similar to previous studies, for example; feeling exposed (Levy et al., 1996), practical material incomprehensible (Nilsson et al., 2007). Some of the described qualities of the therapeutic relationship were also reported previously, for example the therapist being accepting (Glass & Arnkoff, 2000; Lietaer, 1992). The findings of qualitative outcomes also match the other studies. Changes such as sense of empowerment, improved emotional functioning, new awareness/insight, improved interpersonal functioning were also reported in previous studies (Timulak & Creaner, 2010).

Overall, when the two groups are compared there appear to be few differences between them. Nevertheless, the ones that seem to occur (bearing in mind the small number of participants and the absence of statistical evaluation of the differences between the groups) are quite interesting. It appears that Awareness of Problematic Functioning was more typical for poor outcome cases, a feature which was also reflected in the Greater Self-Awareness at the end of therapy. It is unclear why this would be more typical of 'poor outcome' cases. It may be due to the ultra-brief nature of the therapy, insofar as this new awareness may represent the first step in the process of change, indicating that therapy may have finished prematurely for these clients. Some significant events studies have shown that increased awareness can be particularly painful for clients and may encourage them to shy away from therapy and closedown (Labott et al., 1992; Lipkin, 1954).

Surprisingly, the clients who did not benefit from therapy in quantitative terms most frequently reported Mastery of Problematic Experiences as a

helpful impact of therapy sessions. This, however, was not reflected in the qualitative outcomes of therapy where improved coping strategies were reported roughly equally across the two groups. This may well reflect the 'poor outcome' clients' appreciation of any shift in their control over their symptoms. Furthermore, 'good outcome' clients frequently reported experiences of vulnerability as being difficult in the sessions, while the 'poor outcome' clients did not mention this at all. This suggests that 'good outcome' clients, in comparison to 'poor outcome' ones, were more likely to be fully engaged in therapy without excessive control over how they felt. The finding that 'good outcome' clients saw the therapist as an equal, compared to 'poor outcome' clients who rather valued the guidance of the therapist, also fits with the picture of them being more open and less anxious in session. This further suggests that less dependence and greater reliance on their own sense of agency may be characteristic of 'good outcome' clients. Such behaviours may be prior indicators of clients already being strong enough to engage openly in therapy.

In general, we found very little difference between the qualitative accounts of clients defined by quantitative pre-post-therapy measurement as either 'good outcome' or 'poor outcome'. Klein and Elliott (2006), using a larger sample than the one in our study, reported similar findings. It seems, therefore, that we are more likely to uncover differences when comparing the extremes, as in Lipkin's (1948) study, which presents an example of poor outcome and good outcome cases in client-centred therapy. It seems that further studies are necessary in order to acquire greater confidence regarding what changes and experiences of therapy are reported by clients defined by quantitative means as being either 'good' or 'poor' outcome. It may well be that qualitatively, this distinction will be very hard to establish.

Limitations

Owing to several limitations, our study should be treated as a pilot. For instance, the therapy provided was ultra-brief and eclectic/integrative in nature so it is difficult to make theoretically meaningful interpretations or interpretations beyond that therapy format. Furthermore, there were no adherence checking measures to the delivered therapy, so we cannot be sure exactly what theoretical approach was followed. Another limitation is that the interview schedule did not focus on negative changes as a consequence of the overall therapy, focusing only on hindering aspects of the therapy process rather than those associated with outcome. As a consequence, we may have missed some negative changes, which might have helped to further differentiate the two client groups. The interview was also quite general, asking clients to talk about helpful or hindering aspects of therapy without asking them about specific instances/events that would illustrate them. The same applies to changes due to therapy. These were not studied in the context of the clients' everyday life, which might have better captured the distinction between the groups, if it existed.

Implications for practice

An interesting feature of this study which relates to practice concerns the manner in which data from quantitative sources are not entirely consonant with those acquired qualitatively. It is possible that having all clients report onto one quantitative measure (i.e. CORE-OM) may lead to a situation where important data regarding client status is lost; suggesting that the inclusion of some qualitative component in assessing outcome may be appropriate.

Conclusion

In conclusion we suggest that, notwithstanding the limitations outlined earlier, this exploratory study highlights an interesting feature regarding client experience of psychological therapy in a primary care setting. The fact that so few differences were uncovered in the qualitative accounts of therapy and its impact, by the clients deemed by quantitative pre-post therapy measurement as either 'good outcome' or 'poor outcome', may be of interest to those engaged in service evaluation. Our findings suggest that further research may be warranted, examining whether clients that seem to benefit from therapy according to standard pre-post measurement, experience therapy and its impact differently to clients whose pre-post results suggest that therapy did not work.

Acknowledgement

We would like to acknowledge the contribution of Sheila Hawkins, a Senior Counselling Psychologist, whose service hosted the study (South Inner City Partnership in Primary Care).

References

Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., . . . McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology*, *69*,184–96. doi:10.1037/0022-006X.69.2.184

Brettle, A., Hill, A., & Jenkins, P. (2008). Counselling in primary care: A systematic review of the evidence. *Counselling & Psychotherapy Research*, *8*(4), 207–214. doi:10.1080/14733140802453794

Core System Group (1998). *CORE system (Information management) Handbook*. Leeds: Core System Group.

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology*, *32*(3), 307–322. doi:10.1037/0022-0167.32.3.307

Elliott, R. (2000). *Client change interview protocol*. Retrieved from http://www.experiential-researchers.org/instruments/Elliott/changei.html

Elliott, R., & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In J. Miles & P. Gilbert (Eds.), *A handbook of research methods for clinical and health psychology*, (pp. 147–159). New York, NY: Oxford University Press.

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. (2000). CORE: Clinical outcomes in routine evaluation. *Journal of Mental Health*, *9*(3), 247–255. doi:10.1080/713680250

Feifel, H., & Eells, J. (1963). Patients and therapists assess the same psychotherapy. *Journal of Consulting Psychology*, *27*(4), 310–318. doi:10.1037/h0046645

Gershefski, J. J., Arnkoff, D. B., Glass, C. R., & Elkin, I. (1996). Clients' perceptions of treatment for depression: I. helpful aspects. *Psychotherapy Research*, *6*(4), 233–247. doi:10.1080/10503309612331331768

Glass, C. R., & Arnkoff, D. B. (2000). Consumers' perspectives on helpful and hindering factors in mental health treatment. *Journal of Clinical Psychology*, *56*(11), 1467–1480. doi:10.1002/1097-4679(200011)56:11<1467::aidjclp9>3.0.co;2-k

Klein, M. J., & Elliott, R. (2006). Client accounts of personal change in process experiential psychotherapy: A methodologically pluralistic approach. *Psychotherapy Research*, *16*(1), 91–105. doi:10.1080/10503300500090993

Labott, S. M., Elliott, R., & Eason, P. S. (1992). 'If you love someone, you don't hurt them': A comprehensive process analysis of a weeping event in therapy. *Psychiatry: Interpersonal And Biological Processes*, *55*(1), 49–62.

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology*, *53*(3), 314–324. doi:10.1037/0022-0167.53.3.314

Levy, J. A., Glass, C. R., Arnkoff, D. B., & Gershefski, J. J. (1996). Clients' perceptions of treatment for depression: II. problematic or hindering aspects. *Psychotherapy Research*, *6*(4), 249–262. doi:10.1080/10503309612331331778

Lietaer, G. (1992). Helping and hindering processes in client-centered/experiential psychotherapy: A content analysis of client and therapist post-session perceptions. In S. G. Toukmanian & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches*, (pp. 134–162). Thousand Oaks, CA: Sage.

Lietaer, G., & Neirinc, M. (1986). Client and therapist perceptions of helping processes in client-centered/experiential psychotherapy. *Person-Centered Review*, *1*(4), 436–455.

Lipkin, S. (1948). The client evaluates nondirective psychotherapy. *Journal of Consulting Psychology*, *12*(3), 137–146. doi:10.1037/h0060172

Lipkin, S. (1954). Clients' feelings and attitudes in relation to the outcome of client-centered therapy. *Psychological Monographs: General And Applied*, *68*(1), 1–30. doi:10.1037/h0093661

McLeod, J. (2001). Introduction: Research in to the client's experience of therapy. *Counselling & Psychotherapy Research*, *1*(1), 41. doi:10.1080/14733140112331385238

Nilsson, T., Svensson, M., Sandell, R., & Clinton, D. (2007). Patients' experiences of change in cognitive-behavioral therapy and psychodynamic therapy: A qualitative comparative study. *Psychotherapy Research*, *17*(5), 553–566. doi:10.1080/10503300601139988

Paulson, B. L., Everall, R. D., & Stuart, J. (2001). Client perceptions of hindering experiences in counselling. *Counselling & Psychotherapy Research*, *1*(1), 53–61. doi:10.1080/14733140112331385258

Paulson, B. L., Truscott, D., & Stuart, J. (1999). Clients' perceptions of helpful experiences in counseling. *Journal of Counseling Psychology*, *46*(3), 317–324. doi:10.1037/0022-0167.46.3.317

Paulson, B. L., & Worth, M. (2002). Counseling for suicide: Client perspectives. *Journal of Counseling & Development*, *80*(1), 86–93. doi: 10.1002/j.1556-6678.2002.tb00170.x

Timulak, L., & Creaner, M. (2010). Qualitative meta-analysis of outcomes of person centered/experiential therapies. In M. Cooper, J. C. Watson, & D. Holledampf (Eds.), *Person centered and experiential psychotherapies work* (pp. 66–91). Ross-on-Wye: PCCS Books.

Biographies

James McElvaney is a counselling psychologist and PhD candidate at Trinity College Dublin. He is involved in clinical work at the Central Remedial Clinic, Dublin and in private practice.

Ladislav Timulak is a counselling psychologist and Course Director of the Doctoral Programme in Counselling Psychology at Trinity College Dublin. He is an active psychotherapy researcher and also involved in clinical work.