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PI-E: An empathy skills training package to enhance therapeutic skills of IAPT and other therapists

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Keywords: Psychodynamic-Interpersonal Therapy, Conversational Model, Training, Brief therapy, IAPT, empathy.

ABSTRACT

This paper describes a condensed version of psychodynamic interpersonal therapy (PIT), Psychodynamic Interpersonal-Empathy (PI-E), which consists of the first level of competencies of the PIT model. The intention is to use basic psychodynamic principles and skills to enhance delivery of manualised, cognitive therapy based treatments. The intervention is designed to improve two common factors of therapy: the bond between client and therapist, and the ability of the therapist to create positive expectations through an explanation and understanding of the person's problems. Both of these so-called common factors are consistently associated with clinical outcomes.

Training has been developed specifically for low-intensity therapists who are employed in the Improving Access to Psychological Treatment programme. Training focuses upon 5 basic components of PI: negotiation; picking up cues;using statements rather than questions; focusing on feelings and understanding hypotheses. When used skilfully together, these simple components, offer a powerful way of empathizing with and deepening the collaborative work with the client. They all help the therapist to focus upon how the client is feeling 'here and now' in the session. Training in the model has the potential to improve outcomes and reduce drop-out rates by enabling therapists to manage problem scenarios in an empathic way.

INTRODUCTION

PI-E is an abbreviated form of psychodynamic-interpersonal therapy (PIT; Barkham et al, 2017), an evidenced based treatment that was developed in the UK and has been practiced here for over 40 years. PI-E consists of the first level of competencies of PIT. These focus upon the building blocks of therapy, and can be used to enhance most therapeutic approaches, primarily by improving therapists' ability to empathise with their clients, deepen the therapeutic bond, and explore and develop an understanding of their clients' problems.

PI-E can be used as a stand-alone treatment for non-complex symptom problems or as an adjunct to boost the impact and delivery of other psychological treatment approaches, such as low or high intensity Cognitive Behavioural Therapy (CBT) delivered at levels 2 and 3 of the UK Improving Access to Psychological Therapies (IAPT) programme (Clark, 2011).

We have been training local Psychological Wellbeing Practitioners (PWPs) in PI-E for the past three years, augmenting their delivery of low intensity CBT interventions for people with mild to moderate anxiety and/or depression. We are currently in the process of evaluating this work empirically. We have also been teaching PI-E to trainee clinical psychologists as an adjunct to other therapies, particularly CBT.

In this paper, we describe the key features of PI-E and how it can be used to enhance the delivery of CBT interventions. The training we describe currently takes place over three days. Our examples focus mainly on low intensity (I.e. level 2) IAPT treatments but the approach is also relevant to CBT more generally. The aim of the PI-E training is not to teach IAPT practitioners a stand-alone treatment approach, but to teach them certain skills that can be integrated into their normal working practice and thereby enhance their abilities to empathise with clients, to elicit meaningful information and to manage problematic interpersonal scenarios. The ultimate goal is to improve important clinical outcomes, including symptomatic outcome, patient satisfaction,

attendance and treatment adherence, as well as staff satisfaction and retention.

Rationale

A key driver for PI-E was research on the so-called 'common factors' of psychotherapy, therapeutic elements that are common to all psychotherapies regardless of modality, and that appear to have considerable effects upon outcome (Laska et al, 2014). They can be conceptualised in different ways, but the Contextual Model elucidated by Wampold (2015) describes three key common factors: 1) the bond formed between the therapist and the patient; 2) the creation of expectations through an explanation and understanding of the person's problems and the treatment involved; and 3) the enactment of health promoting actions (Wampold, 2015). Specific ingredients of therapy are particular therapeutic actions, which differ across therapies, in which the therapist helps the patient to enact some form of healthy behaviour (e.g. thinking about the world in a less maladaptive way in CBT, or improving interpersonal relationships in Interpersonal Therapy, or being more accepting of one's self in Acceptance and Commitment Therapy).

A series of recent meta-analytic reviews have suggested that elements related to these common factors are much more strongly associated with outcome in psychotherapy than individual differences between therapies (i.e. the differences that can be attributed to specific ingredients). The role of the bond between therapist and client has been examined in several different ways including the alliance (Horvath et al, 2011), empathy (Elliott et al, 2011; Farber et al, 2011; Kolden et al, 2011), and therapist differentials (Kim et al, 2006; Baldwin et al 2007: Del Re et al, 2012). A number of studies suggest that a strong alliance early in therapy predicts positive outcomes later (e.g., Webb et al., 2011, 2012; DeRubeis & Feeley, 1990; Feeley et al., 1990).

Expectations are more difficult to measure but a recent meta-analysis suggests that they also have a small but significant effect on outcome (Constantino et al, 2011).

In contrast, there is little evidence that specific ingredients of therapy have major differential effects on outcome. Several meta-analyses have compared a wide variety of specific therapies for several common mental health problems, and found little or no differences between treatments (Cuipers et al, 2008; Cuipers et al, 2012; Imel et al, 2008;Baardseth et al, 2013; Spielmans et al, 2013; Benish et al, 2007), with a recent authoritative review concluding that the meta-analytic evidence for the superiority of CBT over other therapies is weak or non-existent (Wampold et al, 2017). Not surprisingly, the American Psychological Association (APA) Recognition of Psychotherapy Effectiveness has concluded that comparisons of different forms of therapy most often result in relatively non-significant differences and contextual and relationship factors often mediate or moderate outcomes (APA 2013 , p103).

It is not that 'specific ingredients' are not important, as all therapies have to have ways of helping people change, and it is too simplistic to suggest that common factors and specific ingredients act entirely independently of one another. For example, work on CBT suggests that positive variation in early symptom change, strengthens the therapeutic bond, and that aspects of the alliance related to tasks and goals drive this process (Feeley and colleagues, 1999). In many treatment approaches, however, much greater emphasis is placed on the specific ingredients of therapy, than on their commonalities, or their relationship to the bond between therapist and client.

Understanding the client's perspective and developing a strong working alliance have always been seen as core components of cognitive therapy (e.g., Beck, Shaw, Rush, & Emery,1979) and there is a significant literature on the relational aspects of CBT (e.g., Safran & Segal, 1990; Gilbert & Leahy, 2009). In practice, however, CBT training tends to focus much more on the 'technical' aspects of the

approach, with only minimal attention to rather empathic communication and the therapy relationship (Thwaites & Bennett-Levy, 2007; Department of Health, 2008). The IAPT treatment manuals for low intensity CBT are particularly prescriptive and technique driven. There are understandable reasons for this, as the treatments are meant to be standardised, and deliverable on a mass scale by relatively inexperienced professionals. However, there is very little in the IAPT manualised teaching about the therapeutic relationship or ways to develop an understanding of the client's problems, other than by socratic questioning. PI-E was designed to fill this gap.

Psychodynamic-Interpersonal Therapy

Psychodynamic Interpersonal Therapy (PIT) is also known as the Conversational Model of Therapy, and was developed by British psychotherapist Robert Hobson and his Australian colleague Russell Meares. Hobson (1987) described the main features of the model and its general approach in his book, 'Forms of Feeling', and the theoretical basis of the model has been further elaborated by Meares (1977, 1993, 2000, 2016). A book describing the model and a general treatment manual has recently been published (Barkham et al, 2016).

The full mo**d**el has been evaluated in several randomised controlled trials and has comparative efficacy with CBT for treating depression (Shapiro & Firth, 1987; Shapiro et al, 1995; Barkham et al, 1996). It has also been shown to be an effective treatment for people who present with self-harm (Guthrie et al, 2001), medically unexplained symptoms (Guthrie et al 1991; Hamilton et al, 2000; Creed et al, 2003; Sattel et al, 2012; Hubschmid et al, 2015), high utilisers of healthcare (Guthrie et al, 1999) and borderline personality disorder (Meares et al, 1999; Korner et al, 2006).

At the heart of the model is a focus on the development of a strong, trusting and collaborative relationship with the client. Perhaps more than any other model of

therapy, PIT encourages therapists to constantly focus upon the client-therapist relationship. The simple intention is to really get to ‘know’ the client - not in terms of lots of facts about them, but in connecting with them on an emotional level, and getting to know something of ‘the person inside’. This can only be done by developing a trusting and close alliance.

Empathy is the capacity to understand or feel what another person is experiencing from within the other person's frame of reference, i.e. the capacity to place oneself in another's position. To be able to do this well in therapy, the therapist has to be able to access the inner state, the ‘me’ of the client. There are many definitions for empathy, with cognitive (i.e., perspective taking) and emotional (i.e., shared feeling) aspects often being distinguished. Both require access to the client’s inner world. Although CBT identifies empathy as foundational for good therapy, the skills and processes involved in effective empathic communication are rarely articulated explicitly in CBT teaching (Bennett-Levy & Thwaites, 2007).

PI-E aims to develop participants’ skills in the perceptual and communicative aspects of therapeutic empathy (see Bennett-Levy & Thwaites, 2007), so they are more able to establish warm, close and trusting relationships with their clients. Most components of PI-E are not unique to PIT, but the emphasis that is placed upon getting the simple things right and putting the basic building blocks of therapy into place, before doing anything else, is a unique characteristic of the PIT model.

Integrating two different theoretical approaches

Bob Hobson believed that the word ‘psychotherapy’ had a very broad meaning, including how to respond to a close friend, or a student, or even a neighbour asking for help with a problem. ‘The heartbeat of therapy is a process of learning how to go on becoming a person together with others’ (introduction to Forms of Feeling, 1987).

Although it may seem that cognitive therapy and psychodynamic therapy are very different in their approaches to helping people, we strongly believe that the basics of psychodynamic therapy provide a necessary foundation for all talking treatments. We argue that many therapies place so great an emphasis on theory and technique, that the core aspects of relating are, at best, paid lip-service and at worst, ignored completely.

The aim of the PI-E course was not to turn IAPT PWPs into psychodynamic therapists, but to provide them with simple tools to address relationship issues with their clients in order to help them. In this regard, we did not perceive a conflict between bringing together psychodynamic and cognitive schools of thinking. Such approaches have been successfully integrated into Cognitive Analytic Therapy (Ryle, 1994), many experienced therapists use a range of approaches and techniques in NHS settings, drawing on different psychotherapeutic disciplines.

Low-intensity CBT

In 2007, the then Minister of Health, Alan Johnson, announced the development of a national programme of psychological treatment for people with depression and anxiety, termed the Improving Access to Psychological Therapies (IAPT) Programme (Department of Health, 2007a & b). This has resulted in a fundamental change in the way psychological treatment is delivered in the NHS, with a focus on brief, manualized, mainly cognitive behavioural treatments, delivered by relatively inexperienced therapists. There has been a real expansion in the availability of psychological treatments on the NHS as a result of the IAPT programme, and published outcomes have generally been positive (see http://content.digital.nhs.uk/iaptmonthly). Nevertheless, there has been much criticism of IAPT, particularly over the strict use of manuals that are perceived as

formulaic, overly medicalized and offering a simplistic approach to treating mental health problems (Marzillier and Hall, 2009; Binnie 2015). Results from the programme have also been queried, with some claiming that the true costs of the programme have been underestimated and the positive outcomes inflated (Griffiths & Steen 2013; Griffiths et al, 2013). Indeed, about half of low intensity therapy patients relapse, most within six months of treatment end (Ali et al., 2017). Despite these misgivings, the IAPT programme has become firmly established within the NHS and has an ever widening remit that now includes children, long term conditions and medically unexplained symptoms.

It is not within the remit of this paper to further discuss the relative merits or impact of IAPT. As a result, however, of its development, there is now a very large cohort of therapists who have been trained in low-intensity CBT interventions, and the focus of this paper is concerned with how these therapists' skill-set may be enhanced by a PI-E approach. Current IAPT low-intensity treatments are designed to treat anxiety and depression and to encourage lifestyle changes, using a client-centred and goal oriented approach. They are based on brief CBT interventions including behavioural activation, cognitive restructuring, graded exposure, panic and anxiety management, and problem solving, delivered via guided self-help manuals. A key aspect is working with the client to articulate their difficulties in a 'problem statement', from which a treatment plan can be agreed and appropriate goals set. Within IAPT, low intensity interventions are delivered by PWPs, who receive a year's training to enable them to identify the treatment focus and guide their clients' use of the corresponding treatment manual. They are usually, but not always, psychology graduates who will not have had previous psychotherapy training.

PWPs are taught key interviewing skills including rapport building, flexibility and summarizing, but are expected to stick closely to the manualised treatment approaches. IAPT services are under pressure to see large numbers of clients, and deliver good treatment outcomes with low drop out rates (NHS England, 2015). Whole time equivalent PWPs often see 30 clients or more per week and

have a rapid turnover of clients due to the short duration of the therapies they deliver. Although well intentioned, this has the potential to make treatments unduly formulaic and for therapists to 'miss the person behind the problem'. Our intention in providing empathy skills training for IAPT PWPs is to address this concern.

Barriers to treatment

PWPs see large numbers of clients for brief contracts and often have to deal with quite complex psychosocial problems. Perhaps unsurprisingly, they often encounter barriers to recovery and not all treatments go to plan. Approximately half of people who are assessed by IAPT services either decline treatment or drop out of treatment before it is completed (Health and Social Care Information Centre, 2014). Reasons for dropping out of therapy vary but nearly half of patients who drop out of CBT do so because of low motivation and/or dissatisfaction with the treatment or the therapist (46.7%; Bados et al, 2007). In other words, factors related to either the therapeutic bond or the expectations of the client.

We routinely ask all PWPs who attend our training courses to describe problems that they encounter when delivering low-intensity CBT, with a view to tackling these from a PIT perspective. Commonly cited problem scenarios include:

- Clients attending but being unsure why they have been referred
- Clients attending but feeling that psychological treatment will not be helpful
- Clients talking so much/so little it is difficult to get a clear focus
- Clients presenting with too many problems to get a clear focus
- Clients who are edgy or 'prickly'
- Clients who report they have had a substantial amount of therapy previously
- Clients who have difficulties with ending

- Clients who are sexually inappropriate
- Clients who present safeguarding issues that require a breach of confidentiality
- Clients who have high powered jobs and who are very driven
- Clients who become very distressed in the sessions
- Clients who are therapists themselves
- Clients presenting with relationship problems
- Clients presenting with thoughts of self harm
- Clients agreeing goals but not completing agreed homework tasks
- Clients dropping out of treatment

Many of these problem scenarios have an interpersonal component, but clearly need to be addressed if brief therapy is to be effective (see Leahy, 2008, for a discussion of other 'roadblocks' in cognitive therapy).

In the first half of the PI-E training for PWPs, we help practitioners develop simple PIT skills to arrive at problem statements more efficiently and effectively. In the second half of the training, we focus upon the problem scenarios that they bring, and role-play managing the more common situations using PIT skills. We also include a brief introduction to relevant psychodynamic principles, which are discussed in jargon free language.

In the next sections we will describe the components of PI-E, followed by a brief overview of the theoretical underpinnings of the model we discuss on the course. Finally, we discuss three examples of how PI-E can be used to help PWPs and other CBT practitioners with some of the problems they encounter when delivering therapy. These problem scenarios will be discussed as examples of how the model can be used to improve engagement, enhance treatment and reduce the likelihood of drop out.

COMPONENTS OF PI-E

The PI-E techniques all involve natural aspects of human relating; indeed, most

therapists are already using some aspects of them in their daily practice, as they constitute core aspects of common therapeutic behaviour. However, attending to these basic skills can result in a dramatic improvement in therapists' overall practice; all therapists, no matter their previous experience, can improve this part of their work.

There are five components of PI-E, which when used skilfully together offer a powerful way of empathizing with and deepening the collaborative work with the client. They all help the therapist to focus upon how the client is feeling 'here and now' in the session. Not how the client felt last week or yesterday but right now. Feelings are brought alive and shared, rather than talked about in an abstract way. This is a very powerful tool to get to the heart of the client's problems in a supportive and collaborative fashion.

The five components are:

- Using a negotiating style
- Using statements rather than questions
- Picking up cues
- Focusing on feelings
- Understanding hypotheses

Negotiating style

This involves the therapist adopting a tentative approach, with explicit recognition that their perception of the client's experience may be incorrect and that they wish to understand it better. Phrases like "I'm not sure", "I wonder", "This may not be quite right" etc. enhance the collaborative nature of the process, subtly inviting the client to correct and refine the therapist's understanding of the key issues.

Using statements rather than questions

PWPs are trained to ask questions to elicit information about clients' problems. These are called the '4Ws': Who, When, Where and What. Questioning is also a central component of CBT more generally. The PI-E model offers a complementary approach, which involves making statements, rather than asking questions. Questions tend to push clients into a 'thinking' mode as they try to respond and find an answer. This can be useful, but can also prompt an intellectual response that is divorced from their typical emotional reaction (i.e., 'cold' rather than 'hot' cognition; Rosier and Sahakian, 2013) and/or driven by the interpersonal demands of the situation (i.e., their need to provide the socially 'correct' answer). Questions can also result in finding out a lot of facts about somebody that are 'true' but of minimal significance to managing the problem.

The use of statements in PI-E reflects a goal of getting to 'know' the client on a personal level, rather than 'know about' them in an objective sense. Statements usually facilitate the expression of feelings, which clients can then be encouraged to 'stay with' and explore using other PIT techniques (see below), enabling them to get straight to the 'heart' of their problems. Statements in PIT are always made in a tentative manner.

Picking up Cues (Listening and Noticing)

We devote quite a large proportion of the course to improving the PWPs ability to recognize and pick up cues appropriately. In any model of psychological treatment, it is important that the therapist is vigilant and attentive to what the client is experiencing. This means trying to appreciate, understand and tune into what the client is 'saying', both in their words, and in their tone of voice, behaviour and what they choose not to say. Listening is a major part of the work of the therapist and listening skills can always be enhanced. Listening by itself is not sufficient, however; rather, therapists need to show that they have not only listened, but also noticed and understood. In order to do this, the therapist needs to be alert to verbal, vocal and non-verbal 'cues' that point to how the client is

feeling, as well as cues within the therapist themselves, and to be able to respond to these in an appropriate way.

It is impossible, and probably inappropriate, to respond to all cues from clients, and being ‘too empathic’ can lead to a feeling of intrusiveness in certain situations. However, the most common scenario in any therapy is that therapists miss important cues, even when they feel they are attending to the client. By using PIT skills, therapists become more able to spot these cues when they arise and are better equipped to respond to them empathically.

Focusing on Feelings

We encourage participants to try to help the client bring feelings alive in the sessions. Instead of talking about feelings in the abstract or as if they belong only to the past, an attempt is made to facilitate the client's experience and expression of them in the immediate therapeutic environment.

Understanding Hypotheses

Empathy and sympathy are not the same. Although we want our clients to experience us as sympathetic, there is much more to empathy than ‘being understanding’ and offering someone consolation for their woes. Instead, we need to demonstrate that we ‘get it’. In PI-E, the main device for this is the understanding hypothesis, which take the form of statements that seek to put the client’s current feelings into words. They are more than simple reflections of what the client feels, but an attempt to elaborate on what the client has said, exploring their feelings a little further. Aside from promoting the sense that they have been understood (which can be intrinsically therapeutic), the aim of understanding hypotheses is to establish and extend a conversation about feelings; they promote a shared exploration and understanding of the client's emotional world, and thereby a natural route into the issues that are really bothering them. Understanding hypotheses are always expressed in a tentative manner so they

can be accepted, rejected or modified by the client.

In our experience, a common concern amongst PWPs about understanding hypotheses is a fear of ‘putting words into the client's mouth’, which is seen as non-collaborative and potentially damaging. The key here is that appropriate understanding hypotheses are not plucked out of the air, but are based on the verbal and other cues provided by the client up to that point. In that sense they are much more than just educated guesses. Moreover, they are presented in a tentative manner that conveys a wish to understand, as well as a desire to be corrected if the therapist has misunderstood.

A second concern amongst PWPs is a perceived pressure to ‘get it right’ by offering hypotheses that are ‘accurate’ (I.e., a true reflection of what the client is feeling). Although grossly inaccurate hypotheses are unlikely to be therapeutic, the most important aspect is communicating a strong desire to understand. When done in this spirit, even inaccurate hypotheses can move the conversation forward if they provide a reference point against which the client can articulate their true feelings (I.e., ‘it's not like that, it's like this’).

In both cases, therapists can judge the impact of an understanding hypothesis by observing its effect on the therapeutic conversation; if it has been effective, the therapist should sense a slight ‘deepening’ of the conversation, as the opportunity to discuss the client’s problems, mood or anxiety grows. If such a reaction is not forthcoming, the therapist can acknowledge this (e.g. “I've not got that quite right”), further conveying their desire to collaborate and understand.

Putting the components together

Although the five components are separate skills, when put together they provide an easy, natural approach to discussing feelings. The therapist listens to what the client is saying, picks up cues about feelings using tentative statements, and then tries to help the client focus on their feelings, deepening the discussion

using understanding hypotheses. All this is carried out using a negotiating style, so the client can play an active part in modifying and shaping the conversation.

In the next section we briefly discuss some of the dynamic principles we teach on the course. There is no attempt to teach detailed psychodynamic theory, but we establish a dynamic framework using everyday jargon-free language that provides a rationale for the approach we are advocating.

Basic dynamic principles taught on the course

Attending to the relationship

The first principle concerns attending to the relationship between client and therapist. We argue that all therapy takes place in the context of an interpersonal relationship between two or more people. We suggest that the relationship is the vehicle for change, or the platform upon which therapy is constructed.

Although most therapeutic approaches refer to the importance of the therapeutic relationship, very few devote sufficient attention to this vital aspect of treatment. We focus particularly on client ambivalence, and suggest that clients usually do not want to upset or criticise the therapist, so may only hint at their uncertainty about the therapy. If the therapist is not attending to the relationship, this ambivalence may be missed or avoided and the client may drop out.

Hidden Feelings

Painful or distressing feelings may sometimes be hidden or avoided. This is a natural process that all of us do to a greater or lesser extent. Avoiding painful feelings usually protects people from pain or distress that they find too difficult to bear; in other words, they avoid them for a reason. Asking questions usually does not identify these hidden feelings, either because the client lacks awareness of them or because questioning fails to create the sense of safety that the client needs to discuss them. Enabling someone to experience and share

hidden feelings can lead to a new understanding of their problems, opening up avenues of treatment that might otherwise have been overlooked. As a result, the work is more meaningful to the client and the working alliance is enhanced.

Barriers to change

People create both internal and external barriers to prevent change. These barriers may be unintentional, but they are usually in place for a reason. The barriers may be protective and enable distressing feelings to be warded off. However, barriers usually come at a price, and often mean that the client feels disconnected from themselves and their inner world.

The session as a mirror

Barriers or problems that the client experiences in the external world can also appear in subtle ways in therapy sessions, and be played out between the therapist and client. Therapists should be aware of their feelings towards their client, and should periodically ask themselves: Are the two of you gelling well together, or does the relationship feel clunky and awkward? Do you find it difficult to connect with the client? Are you getting bored? These may be signs that the therapeutic alliance is not very strong, and that there are barriers between yourself and the client. If so, PI-E skills provide a sensitive means of bringing these concerns into the conversation, allowing them to be addressed in a collaborative way.

Misunderstandings or problems are an opportunity for change

Problems between therapists and clients are common in therapy and are often no reflection of the specific skills of the therapist. What is important is that, if problems or misunderstandings arise, they are addressed and repaired (Bennett et al, 2006). If misunderstandings can be addressed in a positive way, the client-therapist relationship often becomes stronger with a better outcome.

Personal issues that may affect therapeutic performance

This is the notion that issues of a personal nature may influence how therapists behave in therapy sessions. It is one of the main reasons why many psychodynamic models suggest therapists should receive personal therapy. On the course we simply ask the participants, in pairs or groups of three, to reflect on aspects of their own personality that may affect the way they interact with clients. This is usually a new and uncharted area for the PWPs and the exercise generates a lot of interest and lively discussion. Common issues identified by the PWPs and their consequences are listed below:

- Appeasing too much in an attempt to avoid conflict, which results in important issues not being addressed
- Fear of failing, which results in trying different interventions as soon as it appears that the client isn't making progress
- A need to reassure people if they become upset, seemingly to avoid the therapist's own discomfort (often resulting in the avoidance of important issues)
- A need to 'make a difference', which results in the therapist persisting with an intervention which may be inappropriate or not working
- A need to have the answers and to appear experienced, which results in a didactic approach and delivering more information than is necessary

For many of the course participants, this is the first time they have been asked to reflect on their own style of inter-relating. Many are able to recognise instances from their own work where their style has influenced their therapeutic practice and their interactions with their clients.

Examples of problem scenarios

In this final section, we provide three illustrations of how PI-E can be used to help PWPs and other CBT therapists manage common problem scenarios.

Problem scenario: Client who is very talkative (a woman in her fifties)

A scenario encountered by most PWPs is of clients who are very talkative and

circumstantial, which can make it difficult to focus on a specific problem area or develop a balanced conversation.

CLIENT: I've been depressed for years, I think it was when Johnny was born, I was just never the same, never the same person, it just came over me, it just came over me and Janet said that I'd changed, nothing felt right after that, I wondered about whether it was because we'd moved house, we moved in the March of that year, I mean it was a nice house, nice enough, but I don't know, it just didn't feel the same, I was just never the same person, and my sleep was just shot to pieces, absolutely shot through……(conversation continues for several more minutes in a similar fashion)

THERAPIST (struggling to get a word in): I wonder if we could pause there….it felt like you were saying something very important….I didn't catch it all….but like you felt you had changed in some way, something 'came over you', as if you are not the same person……(picks up verbal cue) as if you have changed inside……you're not 'you' anymore (understanding hypothesis, statement)

CLIENT (slowing): All the life went out of me….no spark ……I lost my spark…..I was tired all the time…..

THERAPIST: You've lost your brightness, your zest (picks up verbal cue, statement)

CLIENT: No…I'm not the same…. (client makes eye contact, looks distressed)

THERAPIST: A bit like you've lost a part of yourself……(understanding hypothesis, statement)

CLIENT: Yes…yes….myself……I can't enjoy anything….it's just an act…..I pretend…I don't feel anything inside….anything at all….

THERAPIST: I wonder if we could stay with that feeling…….(focus on feeling, statement)

CLIENT: I feel dead inside…..I go through the motions…..I keep busy….

THERAPIST: If you keep busy…..keep your mind busy…..you won't feel this deadness….(understanding hypothesis)

CLIENT: It's a dreadful feeling….yeah……I run myself into the ground sometimes….just to not feel it…

In this scenario, the client gives the therapist a lot of information about her life, but it is like a monologue and it is difficult for the therapist to interject. Amidst all the factual information, the therapist listens for cues as to how the client is feeling. The client refers to not being 'the same person' several times during the excerpt, and it is this part of the client's conversation that the therapist picks up, as it refers to the client's inner world, to the client's self.

When the therapist picks up this verbal cue, the client's speech slows and she is able to get in touch with how she is feeling inside. The conversation deepens, and the client's 'problem' becomes apparent. Further conversation will lead to the definition of a problem statement, from which a specific cognitive behavioural approach can be used to alleviate the client's depression. Once the problem has been elucidated, the rationale for therapy becomes much clearer.

Whilst role playing this kind of scenario on the course, we often find that PWPs either try to intervene by asking a lot more questions, or do not intervene at all, letting the client continue to talk for several minutes at a time. Asking questions in such a scenario typically encourages the client to talk more and go off on other tangents, making it very difficult to identify any kind of focus. Not intervening at all can mean that the session drifts without any real purpose, again making it difficult to identify a focus for intervention.

Problem scenario: Client says very little (a man in his thirties)

Another common scenario is that of a client who says little or nothing.

Example

Silence

THERAPIST: I was wondering if there was anything I could try and help you with today or anything you would like to talk about (statement)

CLIENT: (looks at the floor. Shifts slightly but does not speak)

Silence……

THERAPIST: (moves very slightly forward in her chair)… I guess it's not easy to put into words (picks up non-verbal cue) …but I'd like to know something about what's troubling you…..(tentative style, statement)

CLIENT: (sits silently, looking at the floor. Shoves both hands in his pockets. Looks out of the window).

Silence……..

THERAPIST: I may be completely wrong, but it feels as if you er……you are wondering whether you should have come to see me……. today…... (statement, understanding hypothesis, picking up non-verbal cue)

Silence

CLIENT: I don't know what to say……

THERAPIST… umh……it's a bit strange…. isn't it…coming to see a stranger like me…..(understanding hypothesis, statement) …..perhaps you could tell me a bit about anything you would like help with…..

CLIENT: I don't know what you want me to say….

THERAPIST: Umh…..well that's a bit different….like you feel a pressure from me…..(picks up verbal cue)... but I don't want it to seem that I am expecting you to say something in particular….

CLIENT: (Makes fleeting eye contact with the therapist and takes his hands out of his pockets). It's all a big mess…..

THERAPIST: Umh……so big…..it's hard to put into words……(understanding hypothesis)

CLIENT: (Nods his head)……

Silence…….

CLIENT: Everything seems pointless….(sighs)

THERAPIST: Umh……as if there's no future (understanding hypothesis)

CLIENT: I've just messed up big time…….I'm a gambler…..and I've lost everything…

In this scenario, it is very difficult to build a rapport with the client or develop a problem statement or focus for the treatment, because he finds it so difficult to tell the therapist about his problems. He has very little expectation that psychological treatment can help. The therapist uses the PI-E model to stay with the client's difficulty in sharing how he is feeling. This leads to the client being able to talk about his problems. From this initial step a shared understanding of his difficulties can be agreed and a rationale for treatment.

In the role-plays on the course, PWPs often respond to these kinds of clients by saying little themselves, which typically results in a stalemate, an unbearable increase in anxiety and client disengagement, or by repeatedly questioning the client, which is rarely effective and is also likely to result in the client dropping out.

Problem Scenario: Non-completion of homework (a woman in her thirties)

PWPs and other CBT therapists commonly encounter patients who haven't completed homework tasks that were agreed in the previous session. In this scenario, many PWPs on the course report feeling unable or unwilling to open up

a dialogue about the matter, or a tendency to accept the client's reasons for not being able to do the homework and 'going along' with the suggestion that they try again the following week. Although there may be practical reasons for the non-completion of homework, using PI-E skills to pick up and focus on the client's feelings about the task can often reveal hidden barriers to carrying it out, which can then be discussed and addressed.

CLIENT: I'm afraid I just didn't have time…..I've been so busy this week…..next week is a bit quieter….I've got less on…..I should be able to do it…..
THERAPIST: It's hard when you are very busy…..I know this is the second week you've not been able to do it…..I wonder if it would be good to go back and just review what we agreed……to see if it suits……
CLIENT: I'll be fine….no really……I'll get round to it this week.
THERAPIST: Sometimes it's good just to review things, especially as we set the homework a few weeks ago. I guess one thing for us to think about is that you may be too busy to do something that is set on a regular basis.
CLIENT: Well it is hard….I've got the kids, my mother-in-law's not well, so I've been doing her shopping and popping in to make sure she's ok, and then the boiler broke down……I did wonder about coming today….
THERAPIST: You've got a lot on your plate….. (they discuss the boiler and the client's mother-in-law, then the therapist picks up the client's ambivalence about attending therapy)…I think you said that you wondered about coming today
CLIENT: Yes…well I knew I hadn't done the things you'd set me…..and I just got this sinking feeling…..
THERAPIST: A bad feeling……
CLIENT: Yes……
THERAPIST:…almost as if you've done something wrong…
CLIENT: Yes….exactly….like when I was at school…..'I've not done my homework Miss'. I was always in trouble……I could never do it…..

THERAPIST: It seems that, without meaning to, we've recreated that feeling for you here, between us. The homework is meant to be helpful…..something we agreed jointly…but in reality….it's become a burden…for you…..something you resent a bit maybe?
CLIENT: Well not resent…but I knew I wasn't going to do it….as soon as you suggested something like it.
THERAPIST: I wonder if we need a complete rethink, and start again looking at your problems…..but this time…..with you saying if you feel something's not going to be helpful …
CLIENT: Yeah…that would be good.

In this scenario, the therapist picks up the client's ambivalence about the homework and about attending therapy. The therapist is interested in the client's feelings about the homework, rather than a practical explanation for why it hadn't been done. In doing so, an emotional barrier to completing the task is identified and tackled, increasing the likelihood of the client staying in therapy and benefitting from it.

Personalising the Course to the PWPs' Own Clients

One of the most helpful parts of the course involves PWPs role playing their own clients in small groups. Not only does this enable the PWPs to think of new ways or strategies to help their clients, but it also provides them with greater insight into their clients' difficulties and feelings. It is also in keeping with the ethos of PIT, which is to focus on the micro interactions between therapist and client, rather than talk 'about' therapy.

At the start of the PI-E course, PWPs typically report a tendency not to talk with their clients about difficult feelings, particularly ones that may suggest an ambivalence about attending therapy. They emphasize understandable time pressures and a need to move straight into treatment. However, many of the role plays that the PWPs bring involve clients who are doubtful about therapy being useful, or are wondering why they had been referred for therapy. Using PI-E

skills enables the PWPs to openly acknowledge, discuss and manage clients' doubts about therapy in a constructive, supportive and collaborative manner.

Summary

PI-E is a brief, manual-based set of skills, derived from the broader PIT model, that help PWPs and other therapists to focus on two common factors of therapy: the bond between client and therapist, and the creation of positive expectations through an explanation and understanding of the person's problem. Both require the development of therapists' ability to empathise with their clients. Although the skills arise from a psychodynamic model, they can be woven seamlessly into both low and high intensity CBT to enhance the therapeutic effect. The skills, which can be learnt easily during a short course, enable therapists to manage problematic scenarios that arise in therapy, and to identify client-centred targets for change more efficiently and effectively. They have the potential to improve uptake and outcome of treatment, whilst reducing the risk of disengagement and drop out. There is no attempt to change the specific ingredients of therapy (i.e. the CBT skills themselves) but merely to enhance the delivery of these skills.

We have received very positive feedback from the training courses we have provided to date, and local services report a reduction in dropout rates for therapists trained in the model. We are currently writing up an empirical evaluation of the package (Taylor, 2016).

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