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How Therapists Operationalise the Experiential Components of Person-Centred Experiential Therapy in the Treatment of Depression: Generating Psychotherapeutic Exemplars for Training Practitioners

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ABSTRACT

Background: Person-centred experiential therapy (PCET) is an evidence-based psychological therapy for the treatment of depression delivered within the English NHS Talking Therapies for Anxiety and Depression programme. Process research is needed to understand how therapists operationalise the experiential components which, according to emotion theory, constitute mechanisms of change.

Method: Digital session recordings for 15 PCE therapists in the PRaCTICED trial that received the highest mean score for *experiential specificity, emotion regulation sensitivity* and *emotion focus* were selected and transcribed. NVivo was employed to conduct a qualitative analysis of the transcripts using framework analysis. These three experiential items constituted a priori themes, with the most specific subthemes identified as therapist interventions. Representative exemplars were synthesised from verbatim therapist and client exchanges to illustrate each intervention.

Results: Four themes were identified: reflecting, intensifying feelings, understanding, and active guiding, with 12 subthemes, and 26 types of therapist intervention. The sequence of four themes suggests a range of interventions which reflect increasing activeness of therapist contributions in the session. The procedure adopted demonstrates that it is possible to generate exemplars for psychotherapeutic interventions based on anonymised but real practice which have potential utility for training, supervision and deliberate practice.

Conclusions: Therapists' interventions conform to emotion theory, offering active interventions woven into a nondirective person-centred relationship. The four themes suggested a loose sequence of experiential interventions, beginning with the therapist helping to orient the client towards their emotions, through identifying, articulating and exploring emotions, to working with emotional processes to resolve distress.

1 | Introduction

Person-Centred Experiential Counselling for Depression (PCE-CfD) is a high intensity psychological therapy offered in the English National Health Service (NHS) Talking Therapies for Anxiety and Depression services in England. It is the second most frequently offered individual therapy after cognitive behaviour therapy (CBT), with 72,560 courses of therapy

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Summary

- Greater emphasis in training on interventions which operationalise the experiential components of PCET could enhance the effectiveness and long-term impact of this model of psychological therapy.

delivered in 2022–23, achieving comparable outcomes for clients experiencing depression (NHS Digital 2024). Beyond the NHS, and throughout the current study, this therapy model is known as person-centred experiential therapy (PCET; Barkham et al. 2021).

The efficacy of the model for the treatment of depression has been demonstrated through the analyses of independent trial-based and routine practice data. An analysis of routine NHS Talking Therapies data comprising >11,000 patients receiving either PCET or CBT reported outcomes favouring PCET for moderately severe patients who had attended up to six sessions and for severe patients who attended up to five sessions, although neither result was significant (Saxon et al. 2024). The PRaCTICED trial, a pragmatic, noninferiority randomised controlled trial (Barkham et al. 2021) found that at 6-month postrandomisation outcomes for PCET were noninferior to those for CBT, but at 12 months, although PCET clients maintained their gains, overall results significantly favoured CBT. Apart from the quantitative analyses cited here, and despite the significant impact of PCET on the treatment of depression within the NHS, there is a paucity of research on the model.

While the primary findings of the PRaCTICED trial at a service level were that PCET is cost-effective and noninferior to CBT for the treatment of depression, process research is needed to translate the rich data gathered for the trial into enhanced delivery at the practitioner level. A major strength of the PRaCTICED trial is that it was pragmatic, embedded in an existing NHS Talking Therapies service, with therapy delivered by practitioners employed within the service. Once clients had consented to participate in the trial and were randomised to either PCET or CBT, they received the same service as routine clients. The PCE therapists who participated in the trial had either already qualified in the model or received standard PCET training and were required to meet the usual qualification standards before participating (Barkham et al. 2021; Nye et al. 2019). This means that data collected for the trial, including digital recordings of therapy sessions, represent real rather than ideal practice. Such data are vital as the foundation for research aiming ultimately to enhance practice, for example, by identifying both more and less helpful therapist behaviours (Elliott 1985), and improve outcomes for clients. Importantly, the fact that the context, training and therapeutic practice represented in the PRaCTICED trial are pragmatic means that qualitative research based on this data is recognisable and, therefore, generalisable to other NHS Talking Therapies services, trainers, supervisors and practitioners (Hays and McKibben 2021; Levitt et al. 2021).

The PCET model is an integration of the person-centred relational principles of empathy, congruence, unconditional positive regard and nondirectiveness, with an understanding of the transformation of emotions derived from emotion-focused therapy (EFT; Elliott et al. 2004; Greenberg 2004; Murphy 2019). The term *experiential* captures the therapeutic endeavour of the client experiencing and exploring their emotions within the therapy session, making them accessible for transformation from unhealthy, depressogenic, emotions, towards healthy responses to inter- and intrapersonal events. The PCET model was developed based on evidence of effectiveness from five randomised controlled trials of humanistic therapy in the treatment of depression, two investigating nondirective counselling and three investigating EFT (Sanders and Hill 2014). Two of the EFT trials compared person-centred therapy (PCT) to PCT with added experiential techniques, finding that these components improved the effectiveness of the treatment (Goldman et al. 2006; Greenberg and Watson 1998).

The key experiential components are identified by the Person-Centred and Experiential Psychotherapy Scale (PCEPS-10; Elliott and Westwell 2012; see Supporting Information), which is the primary adherence measure used for this therapeutic model. Of the 10 items of the scale, three have been recognised as defining the experiential components of PCET (Haake 2024). Two of these components are *experiential specificity* and *emotion regulation sensitivity*, which facilitate and enhance the third and central component, *emotion focus*. Although experiential specificity, emotion regulation sensitivity and emotion focus have not as yet been researched as components of PCET, there is evidence for their effectiveness as standalone interventions and as additions to other therapies (Haake 2024). *Experiential specificity* is defined within PCET as the therapist's skill in helping the client to differentiate emotional experiences and to focus on specific rather than general autobiographical memories (PCEPS-10, Elliott and Westwell 2012). Examples of research are reviews by Ahmadi Forooshani et al. (2020) and Hitchcock et al. (2017), which concluded that interventions designed to address over-general autobiographical memory are moderately effective. Studies have found that *emotion regulation* interventions can reduce distressing symptoms, as well as improving clients' emotion regulation (see reviews by Gratz et al. 2015 and Sloan et al. 2017). A meta-analysis by Diener et al. (2007) found that emotion focus (termed affect-focus in the paper) in brief psychodynamic therapy significantly improved outcomes for clients.

In PCET, these components are not delivered according to any protocol; rather, interventions intended to guide the client's emotional process are woven by the therapist into the therapy in the context of a nondirective person-centred relationship (Murphy 2019). However, as a relatively new model of therapy, the experiential components are often unfamiliar to therapists who are beginning their training in PCET. Training is delivered as a 5-day 'top-up' course, followed by 80 h of supervised clinical practice, for therapists who are already trained and qualified, usually with a foundation in person-centred therapy, though this is not always the case. The training curriculum involves revisiting the principles of PCT followed by an introduction to emotion theory derived from EFT (Hill 2011). The 'top-up' model has been criticised as inadequate (Folkes-Skinner 2015), and multiple studies have reported comments by trainees that the time devoted in training to unfamiliar

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experiential concepts is insufficient (Drewitt et al. 2018; Nye et al. 2019; Pearce et al. 2013). Additionally, Haake et al. (2021) found apparent differences between PCET training centres in both the conception of the experiential components, and delivery of training.

In this context, research providing a rich description of how PCE therapists in the PRaCTICED trial operationalised the experiential components has the potential to offer information and guidance for PCET trainers, supervisors and trainees. This guidance would strengthen PCE therapists' confidence in their own practice, and, consequently, clients' confidence in the therapist and in the treatment, two of the common factors in effective psychological therapy (Finsrud et al. 2022; Wampold 2015). At the same time, such analysis would provide a foundation for further research to improve the effectiveness of PCET.

Eighteen therapists delivered PCET sessions in the PRaCTICED trial and therapy sessions were digitally recorded with clients' consent. PCET as delivered in the NHS is defined by a competence framework (Hill 2010) and a training curriculum (Hill 2011), and a manual was written for the trial (PRaCTICED Trial Team 2014). However, the therapy is not standardised (Haake 2018), and therapists evolve their own style of delivery. Using qualitative research, the current study proposed to investigate commonalities in the responses and interventions offered by different PCE therapists in the PRaCTICED trial to facilitate experiential specificity, emotion regulation sensitivity and emotion focus, and how such interventions were incorporated into sessions within the context of a nondirective person-centred relationship (Haake et al. 2021; Murphy 2019).

As well as research based on PRaCTICED trial data being generalisable due to its pragmatic nature, the researchers considered that offering exemplars which capture the essence of interventions, rather than quoting therapists' and clients' words verbatim, would strengthen the generalisability of the findings. Generating definitions and exemplars derived from actual therapeutic material captures the principles underlying such interventions, allowing them to be generalised to multiple situations. That is, rather than presenting results saying: 'This therapist made this intervention with this client', it would be possible to report 'This exemplar is typical of interventions of this sort made by PCE therapists'. At the same time, such a procedure would allow us to avoid citing clients and therapists verbatim, when their agreement to do so may change with the passage of time.

Accordingly, the aims of the study were two-fold: first, to build a rich description of how the PCE therapists in the PRaCTICED trial operationalised experiential specificity, emotion regulation sensitivity, and emotion focus to work with clients' emotional processes; second, to capture the essential principles of interventions that operationalise these components, so that they can be generalised for therapeutic work by each unique therapist–client dyad. The objective was to achieve this by synthesising multiple examples of verbatim exchanges between clients and therapists from real therapy sessions into representative exemplars.

2 | Method

2.1 | Design

Qualitative analysis was selected for this study, which investigates and interprets the internal meanings and intentions of therapists as suggested by their spoken language (Levitt et al. 2021). Epistemologically, this research is positioned within a critical realist paradigm on the presumption that human experience is an aspect of the real world but that it is not accessible to be observed and measured and must be interpreted. The research also adopts a dialectical constructivist paradigm, acknowledging that qualitative research is tentative and cumulative, with the researcher creating meaning in 'dialogue' with the data (Elliott and Timulak 2021; Levitt 2021). The study is descriptive and exploratory, taking an observer perspective (i.e., that of the researcher) with a focus principally on the therapist but also on the therapeutic dyad (Elliott 1991; Hardy and Llewelyn 2015).

The method used is framework analysis (Ritchie and Spencer 2002). This involves five key stages: familiarisation, identifying a thematic framework, indexing, charting and mapping, and interpretation. The framework method facilitates the systematic and visible charting of each participant's contribution within each theme.

2.2 | Participants

The 18 therapists who participated in the PCET arm of the PRaCTICED trial were accredited by an appropriate professional body and were qualified and experienced in humanistic therapy. Years of experience ranged between 7 and 29 years (M = 16.6 years, SD = 5.8), with a mean of 4.6 years (SD = 2.3) since PCET qualification (Barkham et al. 2021). Six therapists had received their PCET training and qualification prior to the PRaCTICED trial, and the remaining therapists received their training and qualification in the service setting as a requirement for participation in the trial (Barkham et al. 2021). Fifteen PCE therapists had session recordings submitted for assessment of therapy adherence and integrity by independent expert raters using the PCEPS-10 (Elliott and Westwell 2012). Of these, 14 were female and one was male.

Of the 15 clients whose recordings provided the source data, 10 were female and four were male, with an age range of 24–66 years. While the majority of clients were white British, there was a mix of ethnicities. One client had no demographic information available.

2.3 | The Person-Centred and Experiential Psychotherapy Scale (PCEPS-10)

The Person-Centred and Experiential Psychotherapy Scale is a 10-item measure designed to assess PCE treatment competence in research and training (Freire et al. 2014). Each item is introduced with a descriptive summary and has a rating scale of 1–6, with each point anchored in a narrative description. The developers of

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the PCEPS stated that anchors for scale points 1–3 were written to reflect practice not seen as competent (Freire et al. 2014). Scale points 4–6 reflect increasing levels of competence, with 6 indicating excellence (Elliott and Westwell 2012). A pass mark in PCET training is set as a rating of 40 or more for a recording segment (i.e., an average rating of 4 across 10 items) out of a maximum of 60.

The PCEPS-10 can be separated into two clusters of items reflecting person-centred principles and the three experiential components. Sampling for the current study involved selecting the recording for each therapist achieving the highest score for the experiential cluster; that is, the highest mean score for experiential specificity, emotion regulation sensitivity and emotion focus combined.

2.4 | Unit of Analysis

The unit of analysis for this study was a therapist intervention, using as many therapist–client speaking turns as necessary to capture each example of an intervention (Elliott 1991; Hill and Lambert 2004). The length of each unit therefore varied between interventions and between therapists and clients. Longer meaning units might also contain differently coded subunits within them (i.e., interventions were counted even if they also appeared within a more complex intervention; Timulak and Creaner 2010). For this reason, some parts of excerpts with several speaking turns met the description for two or more themes.

2.5 | Procedure

The familiarisation stage involved immersion in the material, beginning with transcribing the 15 recordings, with duration ranging from 42 min to 1 h 19 min. These transcripts were uploaded to QSR International's NVivo 12 (2018) for coding. The three experiential components defined in the PCEPS (experiential specificity, emotion regulation sensitivity and emotion focus) provided the a priori themes which formed the basis of the framework analysis. Themes and subthemes were generated inductively from the process of searching for similarities between the verbal behaviours of different therapists within the a priori themes.

Indexing involved a deductive process of reading through each transcript and highlighting all segments which illustrated the use by the therapist of one of the three components. As the commonalities between the verbal behaviours of different therapists were identified, segments which shared these features were clustered together into codes. For each code, a summary was written, describing a therapist intervention. A recursive process of cross-checking between transcripts and codes continued to refine the descriptions until saturation was reached and no new codes emerged.

For the charting stage of the framework analysis, the final summary versions of all the codes/interventions were printed out and placed on a table where they could be viewed and rearranged to reflect different groupings. This inductive process facilitated the identification of broad themes. Within these themes, codes/interventions which captured therapist behaviours at a greater level of detail were clustered together into subthemes.

A framework matrix was created within NVivo, with one column for each therapist, and one row for each subtheme, where each cell contained one or more of the segments of therapist speech which had been coded from the transcripts. From these quotations, an exemplar was created for each code/intervention. This was achieved by imagining a scenario similar to an actual scenario described by a client in a session transcript but changed sufficiently to be nonidentifiable. Similarly, therapist responses were generated which captured the essence of each intervention, synthesised from multiple actual therapist responses, without using any direct quotations.

2.6 | Reflexivity and Trustworthiness

Trustworthiness was considered using Elliott et al.'s (1999) framework. The researcher's own perspective was considered throughout the analytic process. At the time of this research, I (RH) was a PCE therapist and supervisor with 12 years' experience of delivering PCE therapy and took part in the PRaCTICED trial in both capacities, as well as working on a PhD thesis on the subject of PCET. I also completed Levels 1 and 2 of the EFT training. Reflexive awareness was therefore especially important for this qualitative study, based on an interpretative process which introduces subjectivity into the findings.

For the initial coding of therapist speech segments which demonstrated experiential specificity, emotion regulation sensitivity or emotion focus, I continually referred to the definitions given in the PCEPS-10. For the process of clustering similar segments to create descriptions and exemplars, I set aside the PCEPS-10 definitions to focus on the therapist speech. During this process, I also needed to bracket my own understanding of the PCET model, which could lead to making assumptions about a therapist's intentions in making an intervention. For the identification of commonalities within the codes, the focus on the descriptions produced for each code/intervention meant that they were further separated from the original PCEPS-10 definitions and from the therapist speech segments, so that the themes found were new while still meaningfully reflecting the original material.

Credibility and coherence were achieved through a second researcher (GEH) who contributed an independent, non-PCET practitioner perspective, providing a broader overview of psychotherapeutic concepts and detached from the specific details of PCET. The first researcher's initial clustering of codes into themes and subthemes was reviewed by the second researcher, who offered an alternative reading. Themes and subthemes were refined and compared between the researchers three times, until a shared interpretation was reached.

2.7 | Ethics

Ethics approval was granted as part of the submission for the PRaCTICED trial (Health Research Authority, Research Ethics Committee 14/YH/0001; Barkham et al. 2021).

The current authors decided that clients' and therapists' own words would not be reproduced but would be distilled and

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synthesised by them to create representative exemplars of actual practice. This procedure gives total protection for participants' anonymity. Although all participants gave consent at the time of the PRaCTICED trial for their data to be used for research, this decision protected them against any possible changes in their minds over the course of time (cf. Levitt et al. 2021). However, the protection of anonymity meant a limitation for trustworthiness in that results could not be validated by participants and re-engaging participants after some years raises ethical issues.

3 | Results

3.1 | Sessions Sampled for Framework Analysis

For the 15 session recordings represented in this study, the mean ratings awarded by the expert raters ranged from 3.00 to 5.50, median = 4.17, IQR = 0.91.

3.2 | Framework Analysis

Repeated searching through the 15 transcripts resulted in 336 segments of therapist speech which met the definition of one of the experiential components. From the clustering of these segments, 26 codes were identified and 26 summary descriptions of interventions written. Four themes which describe therapist behaviours were identified from the inductive process of grouping the codes/interventions: reflecting, intensifying feelings, understanding, and active guiding. Within each theme, a number of subthemes were identified (see Table 1). The following sections present the results of the analysis for each theme in turn, including tables showing the summary definition for each intervention within that theme (Tables 2–5). Tables showing an exemplar for every intervention are included in the Supporting Information (Tables A–D).

3.3 | Reflecting

The theme of *Reflecting* brought together interventions where the therapist acted as a mirror for the client's emotional experience. Three subthemes were found within this theme. The first, *Using the client's words*, described the therapist echoing the client's words, particularly those containing emotion. For example, if the client said, 'Maybe I'm punishing myself', the therapist might reply, 'Punishing myself?' The second, *Using the therapist's words*, described interventions where the therapist used their own words to feed back their understanding of the client's narrative. This could include observations of the client's emotional process, such as conflicting parts of self; for example, 'it sounds as though part of you knows what you want, but there's another part of you putting up barriers somehow'. The third, *Reflecting the client's nonverbal presentation*, described interventions where the therapist used their own words to describe what they observed of the client's physical presentation; for example, 'I can see the tears coming as soon as you mention the kids'. For all the interventions, the emphasis of the therapist's reflection was on the emotional content of the client's narrative or physical presentation.

3.4 | Intensifying Feelings

The theme *Intensifying feelings* captured therapist interventions which focused on and highlighted the client's emotional

TABLE 1 | Themes and subthemes.

Themes	Reflecting	Intensifying feelings	Understanding	Active guiding
Subthemes	Using client's words	Questioning	Summarising	Containing emotion
	Using therapist's words	Focusing on here and now feelings	Questioning to gain a fuller perspective	Facilitating dialogue between parts
	Reflecting client's nonverbal presentation	Using images and vivid language	Offering a new perspective	Guiding the client's imagination

TABLE 2 | Reflecting: Subthemes and descriptions of therapist interventions.

Subthemes	Intervention description
Using client's words	The therapist echoes the client's own words, usually those words suggesting emotion.
Using therapist's words	The therapist responds, using the therapist's own words, to let the client know that they understand what the client is saying, but without expanding on it or introducing any images or further interventions.
	The therapist reflects the most emotionally poignant aspect of the client's description of their experience.
	The therapist reflects the client's process using the metaphor of 'a part of you', or 'something in you', or reflects an internal conflict as different parts of the client.
Reflecting client's nonverbal presentation	The therapist expresses their observation of the client's physical presentation in that moment, which may reflect the client's here and now emotion.

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TABLE 3 | Intensifying feelings: Subthemes and descriptions of therapist interventions.

Subthemes	Intervention description
Questioning	The therapist asks directly about the emotional aspect of the client's narrative.
	The therapist asks about the client's emotion at the time of the events they are recounting.
Focusing on here and now feelings	The therapist asks the client how they are feeling in the moment, in response to their narrative.
	The therapist makes a tentative guess at an experience the client may be having, based on the therapist's empathic understanding of the client's here and now process and narrative.
	The therapist asks directly about the client's physical sensations associated with an emotion, or observes a physical change in the client, and asks about internal feelings associated with this change. This leads to exploration of the emotional meaning of the sensations, and further exploration of the client's experience.
	The therapist expresses their observation of their own immediate physical or emotional response to the client's narrative.
Using images and vivid language	The therapist finds language or images to capture the emotional essence of a narrative that is literal or abstract.
	The therapist reflects what the client says, conveying understanding, but using more vivid or intense language than the client, or introducing images which heighten the emotional aspect of the client's narrative.

TABLE 4 | Understanding: Subthemes and descriptions of therapist interventions.

Subthemes	Intervention description
Summarising	The therapist sums up in their own words a long client narrative from the session or more than one session, emphasising the emotional aspects.
Questioning to gain a fuller perspective	The therapist uses reflections and questions to help create a full description of the client's embodied experience of emotion, either here and now or remembered.
	The therapist invites the client to recall a specific experience, or a specific instance of a recurring experience, often the most recent example. The therapist offers reflections and questions to build a detailed account of the experience.
	The therapist uses reflections and questions to elaborate a client's recurring experiences. Includes emotional, embodied, cognitive and behavioural patterns.
	The therapist asks questions or offers reflections that guide both the client and the therapist in an effort to understand a client experience that seems puzzling or new, either to the client, the therapist, or both.
Offering a new perspective	The therapist responds, reflecting the client's narrative and introducing a new perspective or way of understanding the client's emotional process.
	The therapist makes an empathic conjecture based on an understanding of the client built up over previous sessions.

experience. The first of three subthemes, *Questioning*, included interventions where the therapist asked a direct question about the client's emotions outside the session, as a response to a familiar event, or at the time of the event the client was describing, such as 'How does it feel when that happens?' The second, *Focusing on here and now feelings*, included questions from the therapist about the client's emotional experience in the session; for example, 'Can you say a bit about what's happening inside you right now, as you're telling me this?' Other interventions within this subtheme described moments where the therapist noticed and verbalised physical changes in the client or in themselves that suggested an immediate emotional experience; for example, 'I noticed that there was a sigh as you began to talk about your son. Can you describe what's happening inside you?' Where the change was in the therapist themselves, the intervention took the form of a therapist self-disclosure; for example, 'It's really touching me inside to hear what you're saying'. A further intervention within this subtheme described a therapist activity of offering a conjecture to the client about what they might be experiencing emotionally in that moment. For example, if a client said, 'Maybe I'm being over-sensitive, but sometimes it seems like some of the jokes are about me', the therapist might respond, 'It feels as though when they're together they sort of gang up on you, and you feel very alone and helpless. I'm wondering if there might be some anger in there as you're talking?'

The third subtheme was *Using images and vivid language*, where the therapist reflected the sense of the client's words but offered an image or used emotionally heightened language to highlight the emotional content of the client's narrative. For

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TABLE 5 | Active guiding: Subthemes and descriptions of therapist interventions.

Subthemes	Intervention description
Containing emotion	The therapist observes a change in the client and that the client seems uncomfortable. The therapist uses reflections and questions to elicit the client's feelings here and now and to work out together if the client wishes to change the topic or to end the session altogether. The therapist offers interventions to contain the client's emotion, to check their safety and to make it possible for the client to continue, or to return for another session of therapy.
Facilitating dialogue between parts	The therapist uses questions and reflections to guide the client in exploring and working towards understanding different parts of themselves, and the relationship between them.
	The therapist uses questions and reflections to help the client express feelings on behalf of each part of themselves, and sometimes towards another part.
	The therapist helps the client to identify and give expression to an encouraging or affirmative part of themselves.
Guiding the client's imagination	The therapist invites the client to say in the session things they wish they could say, or could have said, to someone in their life.
	The therapist guides the client through an exploration of an emotional experience that is hypothetical, but relevant to the client's concerns.

example, if a client said, 'It does get me down sometimes', the therapist might reply, 'It sounds as though you feel completely battered by it'.

3.5 | Understanding

The theme of *Understanding* captured a therapist's efforts either to convey their own understanding of the client's narrative and process, or to help the client to make sense of their experience. Three subthemes were identified within this theme. *Summarising* described the therapist activity of succinctly reflecting the sense of the client's narrative in the therapist's own words, with an emphasis on the emotional content. *Questioning to gain a fuller perspective* captured the therapist offering a range of interventions in the form of questions or reflections which elicited an increasing amount of detail from the client about their experience, including physical, cognitive, and emotional experiences, remembering past events as well as experiencing within the session. For example, 'Can you think of the last time you felt like this, maybe in the last week? Could you set the scene for me?'

The final subtheme, *Offering a new perspective*, described therapist responses where they offered the client an alternative understanding or way to make sense of their experience, such as 'It sounds like there are different levels to what's happening to you. Your body is going through this horrible experience, and at the same time your head is thinking "What's happening to me? This doesn't make sense!"' One intervention captured a therapist communication where this understanding was based on a view of the client or their story built up over previous sessions; for example, 'I keep noticing that you're a really kind person, and I wonder if that makes it even harder for you'.

3.6 | Active Guiding

The theme of *Active guiding* encapsulated segments where the therapist went beyond reflections and questions to offer interventions which guided the client's emotional process within the session. The first of three subthemes, *Containing emotion*, described an intervention where the therapist guided the client through overwhelming feelings. For example, when a client's distress made them want to leave the session, the therapist checked their safety on leaving, how they could comfort themselves once they'd left, and their wishes for continuing the therapy. *Facilitating dialogue between parts* involved the therapist inviting the client to talk about their experience in terms of parts of themselves or to inhabit different parts to talk from the emotional experience of each part separately. Included within this subtheme were interventions where the therapist guided the client in identifying and acknowledging a positive or comforting part of themselves. For example, a therapist might respond to a client who said they felt rubbish most of the time, but occasionally felt proud of themselves, 'It sounds as though there is a part of you that can feel proud of what you've done. Can you say a bit more from that part?'

The final theme, *Guiding the client's imagination*, captured interventions where the therapist invited the client to picture an imaginary event in order to experience and talk through the associated emotions, including talking to a person who was not present, or imagining places or people that raised feelings for the client in real life. For example, a therapist might respond to a client saying, 'It sounds as though all of it is churning around inside you whenever you see him. Could you describe what would happen inside you if he walked into this room right now?'

4 | Discussion

Regarding the first aim of this study, to build a rich description of how the PCE therapists in the PRaCTICED trial operationalised the experiential components of the model, the analysis demonstrated that although the style of individual PCE therapists can be quite different, there are commonalities in their practice which reflect the theoretical components of PCET.

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From these commonalities, it is possible to draw out and define specific interventions intended to operationalise the theoretical mechanisms of change.

The theme of *Reflecting* captured interventions which oriented or 'nudged' clients towards their emotional experience while remaining in the client's frame of reference (Elliott 2022). Interventions demonstrating the therapist's emotion regulation sensitivity, working to bring the client into a productive level of emotional arousal (Elliott et al. 2004; Elliott and Westwell 2012) by using vivid language, images and questioning to highlight and strengthen the emotional content of the client's narrative were labelled as *Intensifying feelings*. Therapists also used interventions which elaborated the client's emotional experience in service of insight, labelled as *Understanding*. Process-guiding interventions were identified under the theme of *Active guiding*. These interventions included those where the therapist helped to contain the intensity of the client's emotions, providing a structure that enabled clients to work with their feelings within a safe space. Other process-guiding interventions were used by therapists to evoke the client's emotional experience, bringing feelings into the client's awareness, symbolising them in words and images such as 'parts of self', thus making them accessible for exploration (Greenberg and Paivio 2003).

When the themes and interventions identified in the overall analysis are arranged in this order, a flexible sequence of therapist activity is suggested. First, the therapist helps to orient the client towards their emotional experience, followed by identifying, articulating and exploring emotions, before using process-guiding interventions which work with emotional processes to resolve their distress.

The themes, subthemes and interventions identified here reflect the real-life practice of therapists in the PRaCTICED trial and delivering PCET as routine practice within the NHS Talking Therapies programme. As noted in the Methods section above, the PCE therapists in the PRaCTICED trial were relatively inexperienced, and adherence scores for the session recordings varied widely. Nonetheless, the findings suggest that, as noted by Stiles (1979), the 'strategy' of each therapist demonstrated their understanding of PCET as an integration of nondirective person-centred therapy with experiential theory, and their 'tactics' operationalised the theory in the form of the interventions identified here. The therapists in this sample did not formally propose activities such as working with parts of self, but instead noticed when opportunities for such interventions arose naturally within the client's narrative. They were then able to weave process-guiding interventions seamlessly into the person-centred therapeutic relationship.

Further analysis would be necessary to determine how successful the therapists' individual emotional processing proposals were in deepening clients' emotional experience moment by moment (Sachse 1990). As described in the Introduction, findings from previous research on the experiential components from other therapeutic modalities, including EFT, suggest that emotion-focused interventions enhance the effectiveness of psychological therapy for depression over and above the person-centred relationship. Future research should explore the possibility that greater focus by the therapist on these experiential elements might improve the long-term effectiveness of PCET, so that, as with CBT, outcomes for clients continue to improve beyond the end of therapy (Barkham et al. 2021).

Regarding the second aim of this study, to capture the essential principles of interventions that operationalise the experiential components of PCET, we have taken a novel approach in providing exemplars which can be generalised for each unique therapist and client dyad. These exemplars are taken from, but do not use, direct quotes from the therapy transcripts. The purpose was to illustrate the interventions as used in working practice, rather than to show an ideal intervention. The hope is that providing such exemplars will enhance PCET trainees' understanding of the experiential components of the model and their confidence in their own practice, consequently strengthening clients' confidence in the therapist and in the treatment. The definitions of interventions and the exemplars offered here may also provide a foundation for future process research aiming to identify both more and less helpful PCE therapist behaviours.

I (RH) found the process of immersing myself in the therapeutic work of fellow PCE therapists fascinating and supported my confidence in my own work. As a supervisor and member of a supervision group, I hear about the work of others, but the necessarily private nature of the person-centred relationship between client and therapist means that it is rare to observe actual practice. Through this study, I felt privileged to work with the therapeutic contributions of colleagues. Some interventions (e.g., the use of therapist questions or tentative interpretations) are controversial in PCT, but the current analysis suggests they are common in practice and potentially effective in helping the client explore their emotional experience.

5 | Strengths and Limitations

The major strength of this study is the sample of recordings drawn from the PRaCTICED trial, a pragmatic trial conducted in routine NHS Talking Therapies settings, so that the delivery and process of therapy was no different to real-world PCET practice. The PCE therapists represented here were trained and qualified, but not necessarily expert. Although the sampled therapy sessions were identified using the highest mean rating for the three active components, the sampling frame of sessions from 15 different therapists meant that a wide range of competence levels was represented, again reflecting real-world conditions. The use of exemplars rather than direct quotes helps to mitigate the influence of an individual or inexperienced therapist. However, these interventions may differ from those of more experienced PCE therapists.

The recordings and transcripts reflected a range of therapist activity, with some therapists offering very few interventions, and others offering interventions within every theme. The current study does not, however, offer any analysis of which interventions were used most frequently, or which might be most effective in guiding clients through their emotional experience.

The study is limited by relying on the perception and interpretations of the observer–researchers. The data available for the current study meant that therapist intentions had to be interpreted

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by the principal researcher from their verbal behaviour, in contrast to methodologies which include postsession reporting by participants (Elliott 2010).

The use of the a priori themes of experiential specificity, emotion regulation sensitivity and emotion focus, and the subjectivity described here, may have introduced confirmation bias to the results. The emergent themes relied on the interpretation of the two co-researchers, meaning that other researchers may identify different themes, or classify the therapist interventions identified for this study differently.

6 | Conclusions

The findings of the qualitative analysis showed that PCE therapists operationalised experiential specificity, emotion regulation sensitivity and emotion focus in a range of ways in the PRaCTICED trial. Therapist activity increased between orienting clients towards their emotional experience, to helping clients to identify, articulate and experience their emotions, before offering process-guiding interventions aimed at resolving emotional distress. Therapists actively promoted the client's awareness and focus on their emotional process, while respecting the client's frame of reference and the person-centred principle of nondirectiveness. Future process research needs to evaluate the effect and effectiveness of specific interventions, and the effect of therapists being more or less active within the session. Research which includes the client's perspective would also complement and reinforce the findings of the current study.

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Conflicts of Interest

The authors declare no conflicts of interest.

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