A longitudinal Investigation into the Relationship between Rogers' Therapeutic Conditions, Experiencing, and Authenticity

By

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Abstract

Introduction

Rogers (1957, 1959) delineated six necessary and sufficient conditions for constructive personality change, implicitly outlining a pathway in which the client's perception of the three therapist's conditions precedes internal processes and subsequent constructive personality change. Nevertheless, empirical investigations rarely analyse these six conditions within an integrated sequential framework that distinguishes relational factors, internal processes, and personality outcomes over time. The present study aims to fill this gap by examining, in a longitudinal study, whether clients' perceptions of the therapist's conditions during the early phase of therapy predict later levels of authenticity in therapy, and whether this relationship operates through the way clients engage with their experiences during the mid-phase of therapy.

Method

Data were drawn from the Human Flourishing Project research clinic in Nottingham. A longitudinal design was employed using theoretically aligned measures: the Barrett-Lennard Relationship Inventory to assess clients' perceptions of the therapist's conditions, the Experiencing Scale to capture clients' moment-to-moment engagement with felt experience, and the Authenticity Scale to index constructive personality change. Measures were collected across early, middle, and later phases of therapy (sessions 5, 10, and 15). Analyses included principal component analysis, bivariate correlations, multiple and categorical regression analyses, mediation analysis, and cross-lagged panel designs to examine temporal ordering and process pathways.

Results

Clients' earlier perceptions of the three therapists' conditions were associated with later engagement with their inner experience and subsequent authenticity,

whereas reverse pathways were not supported. This finding is consistent with a potential unidirectional relational process, though the evidence is probabilistic rather than conclusive. Mediation analyses did not reveal significant effects, indicating that the hypothesised indirect pathways were not supported. Categorical regression analyses suggested that clients at Level 3 of experiencing mid-therapy were more likely to demonstrate meaningful subsequent changes in authenticity than those at lower or higher levels, implying that moderate engagement with inner experience may be associated with later improvements, while higher levels of experiencing are not necessary for positive outcomes.

Conclusion

In conclusion, the findings do not definitively confirm or refute Rogers' (1957, 1959) hypothesis regarding the six necessary and sufficient conditions for constructive personality change. This suggests that the quality of the therapeutic relationship sets the stage for subsequent constructive movement toward growth. Notably, higher levels of authenticity emerge once clients reach a moderate, accessible level of experiential awareness, rather than through deliberate or intensive exploration of inner experience. These findings indicate that the relational conditions alone provide a sufficient foundation for later levels of clients experiencing and authenticity.

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Abbreviation Table

Abbreviation	Full Form
AS	Authenticity Scale
AT	Actualising Tendency
B-LRI	Barrett-Lennard Relationship Inventory (OS.40)
CCL	Cross-Lagged Correlation
CLPD	Cross-Lagged Panel Design
EFA	Exploratory Factor Analysis
EXP	Clients' Experiencing Scale
HFP	Human Flourishing Project
OVP	Organismic Valuing Process
PCT	Person-Centred Therapy
UPR	Unconditional Positive Regard

Chapter 1: *A Longitudinal Investigation into the Relationship between Rogers' Therapeutic Conditions, Experiencing, and Authenticity*

1.1 General Introduction

Psychotherapy research continues to return to a deceptively simple question: what allows clients to change? Despite decades of outcome research, this question remains unresolved, particularly when change is understood as a movement away from alienation and toward greater psychological congruence. Among the most influential responses is Rogers's proposal of six necessary and sufficient conditions for constructive personality change. Rogers argued that when a therapist is congruent, empathically understanding, and holds an attitude of unconditional positive regard, and when an incongruent client perceives these attitudes within a relationship of genuine psychological contact, constructive personality change becomes possible (Rogers, 1957).

Rogers (1959) later framed the six necessary and sufficient conditions as a relational sequence. The therapist's attitudes create a facilitative psychological climate in which the client's actualising tendency can function more freely, guiding the person toward a more integrated and authentic way of being. Central to this formulation is the claim that change does not reside in therapists' attitude, but in clients' perception of these relational conditions as they are lived and experienced over time. This claim is among the most ambitious propositions in psychotherapy theory. Rogers did not suggest that empathy, congruence, and

unconditional positive regard are merely helpful factors; he advanced a six necessary and sufficient causal account of personality change itself. Such a claim sets an exceptionally high empirical bar. It requires not only that relational conditions be associated with positive outcomes, but that they precede and give rise to change through an identifiable psychological process unfolding across time.

Early empirical attempts to test this hypothesis, particularly following the Wisconsin Project, struggled to meet this challenge. Research relied heavily on observer-rated instruments such as the Truax and Carkhuff scales to assess conditions 3 to 5 (Rogers et al., 1967). These measures privileged external judgements over the client's phenomenological experience and gave limited attention to how the therapist's attitudes were perceived by the client. While Truax and Mitchell (1971) suggested that minimal levels of perceived empathy, congruence, and unconditional positive regard were sufficient for positive change across therapeutic approaches, these studies did not examine the relational sequence Rogers described, nor the temporal process through which change was proposed to occur.

In doing so, early research subtly fragmented Rogers's hypothesis of the six necessary and sufficient conditions. Therapists' attitudes were treated as independent facilitative factors, and client outcomes were assumed to follow directly from their presence. Condition 6—requiring that the client perceive empathy and unconditional positive regard—was frequently omitted. As Rogers (1961) emphasised, "it is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried." Without the client's perspective, the six necessary and sufficient conditions hypothesis can be tested only partially and offers no clear account of how change occurs. Barrett-Lennard (1962) recognised this limitation early, arguing that without

incorporating the client's experience of the therapist's attitudes, Rogers's theory could not be examined in its original relational and temporal form. Although the measures developed during this period refined the assessment of therapeutic relationships, they did not resolve the core methodological problem: how to operationalise a theory that locates change within the client's lived experience as it unfolds over time.

Recent developments in person-centred research now make it possible to revisit Rogers's hypothesis more directly. Limitations in early measures highlighted a central problem: Rogers's conditions could not be adequately tested without tools capable of assessing the client's perception of the therapist's attitudes. In response, later person-centred instruments were developed to prioritise the client's phenomenological experience (Barrett-Lennard, 1998; Brodley & Brody, 1990; Freire et al., 2007; Wood et al., 2008). The Authenticity Scale (AS; Wood et al., 2008) operationalises movement from self-alienation toward congruence through client self-report, while the Barrett-Lennard Relationship Inventory (B-LRI; Barrett-Lennard, 1998, 2002) assesses the client's perception of therapist empathy, congruence, and unconditional positive regard, thereby directly addressing the six conditions in Rogers's hypothesis. These developments have renewed quantitative investigation into human flourishing by enabling the operationalisation of constructs closely aligned with Rogers's theoretical vision.

Despite these developments, Rogers's six necessary and sufficient conditions hypothesis (1957, 1959) has never been examined within a single longitudinal model that reflects its full relational and temporal structure. Existing evidence nevertheless converges on the pathway Rogers anticipated. Meta-analytic findings show that clients' perceptions of therapist empathy, congruence, and unconditional positive regard are consistently associated with client

outcomes, with effects strongest when assessed in the early phase of therapy (Elliott et al., 2018; Farber et al., 2018; Kolden et al., 2011). Further meta-analytic work indicates that the therapeutic relationship is associated with higher levels of experiencing, with medium effect-size associations observed particularly during mid-therapy (Pascual-Leone & Yeryomenko, 2017). Process-oriented studies similarly report that stronger experiential engagement is associated with developmental outcomes such as post-traumatic growth (Zwiercan, 2018). Longitudinal findings also suggest temporal ordering: Bayliss-Conway et al. (2021) found that clients who perceived stronger therapist conditions by session five reported higher levels of authenticity at later sessions. Developmental accounts describe a parallel trajectory toward congruence characterised by increasing self-awareness, self-acceptance, and openness (Stephen, 2023). Taken together, this literature suggests that early client perceptions of the three therapist conditions organise the therapeutic relationship over time, supporting deeper experiential engagement and later movement toward authenticity.

This thesis is situated within the Human Flourishing Project (HFP), a person-centred research clinic that collects repeated session-level data using client-completed measures alongside audio recordings of therapy sessions. To examine Rogers' hypothesis in a manner consistent with its original formulation, temporal direction is conceptualised within a single, integrated longitudinal model. Within this model, the six necessary and sufficient conditions are specified as the initiating condition of change in early therapy. The model then incorporates a process variable that captures how these perceived conditions are received and taken up experientially by the client, reflected in their manner of emotionally engaging with felt experience during the mid-phase of therapy. Finally, constructive personality change is indexed by a developmental outcome reflecting later authenticity levels at termination.

This chapter introduces the longitudinal investigation into the relationship between Rogers' therapeutic conditions, experiencing, and authenticity. It outlines the theoretical foundation of the study, defines the research problem and gap, and introduces the HFP as the context for the investigation. The chapter then presents the conceptual framework, including Rogers' six conditions, the process variable, the outcome variable, and the temporal design. It further sets out the research objectives and significance of the project, before concluding with an overview of the thesis structure.

1.2 Theoretical Foundation

Rogers (1902–1987), the founder of person-centred therapy (PCT), formulated his theory of personality over several decades of clinical practice and theoretical refinement (See Barrett-Lennard, 1998; Kirshenbaum, 2004; Kirshenbaum, 2007; Kramer, 1995). Rogers began his career in the 1920s and 1930s, introducing *a non-directive approach* based on the belief that clients grow when freed from external authority. His early work showed that when therapists refrained from directing the client, space opened for emotional exploration. Nevertheless, he soon recognised the limits of this method. Many clients remained distant from their internal experience. Non-directiveness reduced hierarchy, but it did not resolve the deeper incongruence and defensiveness that shaped their distress. Something more was needed.

During the 1940s, Rogers' thinking shifted as he drew on Raimy's (1943) concept of *self-concept*. He realised that clients often defend a threatened sense of self and avoid feelings that challenge how they believe they ought to be. Building on Standal's (1954) ideas, he described how *conditions of worth* and conditional self-regard interfere with the *organismic valuing process* (OVP), the internal guide through which individuals' sense what is right for them. When the

OVP becomes restricted, individuals move away from their lived experience and become increasingly alienated. This tension between lived experience and self-concept lies at the heart of incongruence.

In the early 1950s, Rogers turned toward a more phenomenological perspective. He emphasised the importance of the *here and now* of experiencing and argued that change occurs when clients attend to the immediate felt sense of their internal world (See Kramer, 1995). This shift represented a deeper focus on experiential process. Rogers saw that therapy is not about analysing the past but about supporting the client's capacity to encounter their experience as it emerges in the present moment. At the same time, he articulated the *actualising tendency* (AT), which he described as an inherent movement toward growth, differentiation, and constructive living. He argued that the AT becomes restricted when clients feel judged, unsafe, or evaluated. This led him to identify a specific relational climate that allows the AT to operate with congruence, unconditional positive regard, and empathic understanding. These attitudes, when experienced together, create a psychological environment in which clients feel able to lower defences and approach their own experience.

Rogers brought these ideas together in his 1957 and 1959 writings, in which he places the quality of the therapeutic relationship—as experienced by the client—at the centre of psychological change. Rogers expressed this most clearly in his hypothesis of *six necessary and sufficient conditions for constructive personality change* (see Table 1.1): when all six conditions are present, constructive change follows. Rogers argued that the three therapists' conditions cannot facilitate growth unless the client experiences them as genuine. This focus on the client's perception marks a significant shift in his theory: the

relationship becomes transformative not simply because of what the therapist does, but because of how the client receives and perceives it.

Table 1.1 Rogers' Necessary and Sufficient Conditions for Constructive Personality Change

Condition Number	Rogers' Necessary and Sufficient Condition
1	That two persons are in psychological contact.
2	That the first person, whom we shall term the client, is in a state of incongruence, being vulnerable, or anxious.
3	That the second person, whom we shall term the therapist, is congruent in the relationship.
4	That the therapist is experiencing unconditional positive regard toward the client.
5	That the therapist is experiencing an empathic understanding of the clients' internal frame of reference and endeavours to communicate this experience to the client.
6	That the client perceives, at least to a minimal degree, conditions 4 and 5. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

Note. Adapted from Rogers (1957)

He later expanded this work through the *seven stages of process* (1958/1961), which describe how clients move from rigidity and defensiveness toward openness and congruent living. Early stages are marked by distance from internal experience, while later stages show increasing willingness to contact and express deeper feelings. Rogers viewed this progression as a sign of reduced incongruence and the gradual restoration of the OVP. For Rogers, the outcome of

therapy is movement toward becoming a *fully functioning person*. This involves openness to experience, trust in the OVP, and reduced alienation. Authenticity becomes possible when clients no longer depend on external conditions of worth and can rely more fully on their internal sense of direction.

Therefore, these concepts form the theoretical foundation for the present thesis. Rogers' progression from non-directiveness to a relational and experiential model of change outlines a clear pathway: clients perceive the therapist's attitudes, engage with their internal experiencing, and later become authentic.

1.3 Research Problem and Gap

Rogers's six necessary and sufficient conditions form a coherent relational configuration in theory, yet their application in psychotherapy research has often been misunderstood. A major cause of this confusion lies in the chronological order of Rogers's publications. Although the 1957 and 1959 papers are theoretically connected, the earlier one was published first, preceding the more comprehensive account published two years later. As Tudor (2011) noted, this reversed publication order led to an exaggerated emphasis on the three therapist conditions, a tendency further strengthened by Rogers's use of an if–then formulation in the 1957 paper. While this structure was essential to make the hypothesis empirically testable, it also encouraged a linear interpretation in which the if is seen as the three therapists' attitudes and the then as client change, implicitly viewing therapy as a one-way causal process rather than a relational and temporal interaction (see Tudor, 2011).

Much of the empirical literature emerging in the 1960s and 1970s consequently examined the three therapist conditions as separable variables. Studies of the so-called "core conditions" are therefore not without value (e.g.,

Mitchell et al., 1977; Olinsky & Howard, 1987; Truax & Carkhuff, 1967), but they become conceptually problematic when detached from the broader hypothesis of the six necessary and sufficient conditions. As Tudor (2011) argued, the three therapist conditions cannot be meaningfully evaluated as causal influences unless they are situated within the complete relational system articulated in 1959, in which all six conditions operate simultaneously through the AT and within a temporally unfolding process grounded in OVP. The if–then structure thus refers to the concurrent presence of the full configuration of conditions, rather than to isolated therapist inputs producing client change.

Joseph (2015) pointed out that constructive personality change depends on recognising the organismic nature of human functioning. A therapist might consistently offer congruence, unconditional positive regard, and empathy; however, for therapy to succeed, the client must establish psychological contact (Condition 1), experience incongruence (Condition 2), and perceive and receive the three therapists' conditions as genuine (Condition 6). Conditions 3, 4, and 5, therefore, depend on the presence of the first three conditions, which are essential for therapeutic success. Therefore, the six necessary and sufficient conditions are fundamentally interconnected. Reliance on the 1957 paper alone, therefore, risks abstracting the conditions from their theoretical context, whereas the 1959 paper offers the most complete representation of Rogers's theory of personality. Accordingly, this thesis treats the two papers as theoretically inseparable.

Additionally, the three therapist conditions function as a unified relational whole rather than as separable components. Empathy (Condition 5) depends on congruence (Condition 3) to remain genuinely lived rather than technical or imitative, as entering the client's internal frame of reference requires the therapist to be in contact with their own experiencing. Congruence alone,

however, lacks therapeutic direction unless it is oriented toward the client through empathic understanding (Condition 5). Unconditional positive regard (Condition 4) is likewise inseparable from both conditions: it must be genuinely held (congruence) and conveyed through empathic understanding if it is to be received by the client, rather than remaining an internal stance. In this way, the three therapist conditions presuppose one another and only acquire therapeutic significance within the full six necessary and sufficient temporal process.

Consequently, Rogers' six necessary and sufficient conditions cannot be meaningfully tested when any one condition is absent. Examining empathy (Condition 5) without client perception (Condition 6), or retaining congruence (Condition 3) and empathy (Condition 5) while excluding unconditional positive regard (Condition 4), does not constitute a test of Rogers' hypothesis When any condition is removed, the relational system Rogers described is disrupted, the hypothesis is fragmented, and such studies are not testing Rogers' necessary and sufficient conditions as a unified framework.

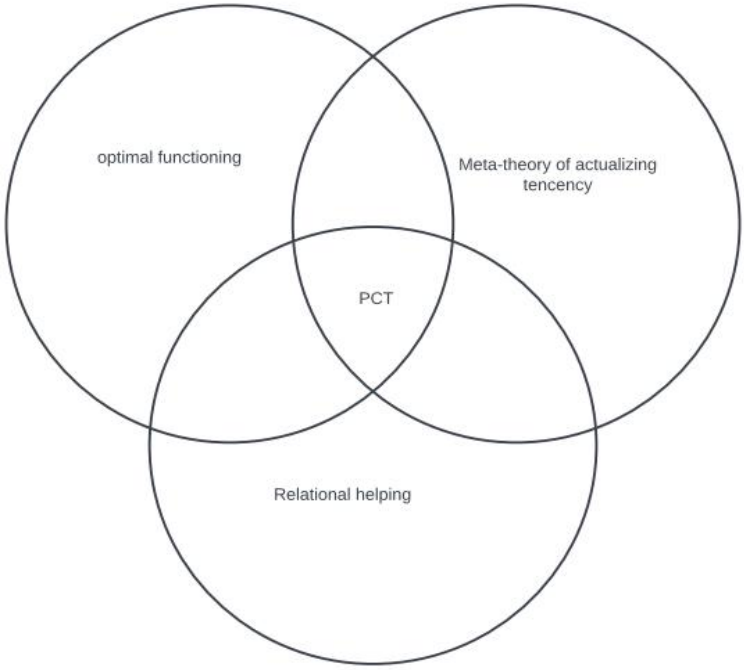
Accordingly, there remains a gap in empirical research that genuinely tests Rogers' (1957, 1959) hypothesis as formulated. The hypothesis is not concerned with the six conditions in isolation, but with the process of constructive personality change that they are proposed to set in motion. In Rogers' hypothesis, the six conditions specify the relational prerequisites that allow the client's AT to operate through experiencing, facilitating the loosening of introjected values and the restoration of organismic valuing over time. Studies that do not model this process are therefore not testing Rogers' hypothesis, even when individual conditions are measured.

Joseph and Murphy (2013) help to re-situate Rogers' PCT (see Figure 1.1) by depicting it as the intersection of three overlapping domains: relational helping, the meta-theory of the AT, and optimal functioning. PCT lies at the

centre of this configuration, where all three domains converge. Within this Venn diagram, Rogers' six necessary and sufficient conditions can be understood not as discrete causal inputs, but as the relational mechanism through which the AT operates toward optimal functioning. In this way, the Figure 1.1 visually counters linear readings of the *if–then* formulation by repositioning the three therapist conditions as part of an integrated relational system rather than as independent causal agents.

Figure 1.1

Overlapping areas of interest



Note. Adapted from Joseph and Murphy (2013)

The essence of PCT lies in helping individuals reconnect with their OVP, counteracting external conditions of worth that may disrupt alignment between real experience and ideal valuing. Figure 1.1 shows that the three therapists' conditions (i.e., relational helping) are meaningful only insofar as they operate in relation to the AT and the client's organismic optimal functioning (Joseph & Murphy, 2013; Rogers, 1959). Being empathic, congruent, and unconditionally accepting does not, in itself, define PCT.

Research designs that isolate variables, collapse time, or rely solely on pre–post outcomes cannot test the hypothesis as an integral framework, because they omit the developmental and experiential process that defines it. Much existing research has relied on cross-sectional designs, short-term outcome studies, or intervention-focused models, thereby examining components or correlates of Rogers' hypothesis. Such studies may inform specific aspects of the six conditions, but they do not constitute a test of Rogers' six necessary and sufficient conditions as a unified relational–process model.

However, examining Rogers' hypothesis requires longitudinal data collected within an ongoing, non-directive therapeutic relationship, along with access to session-level process material, such as audio recordings. Rogers explicitly rejected the view that therapeutic outcomes arise from the application of specific techniques, yet research designs capable of capturing relational and developmental processes over time remain difficult to implement. Following early attempts such as the Wisconsin Project (Rogers et al., 1967), quantitative research explicitly designed to examine the six necessary and sufficient conditions as a process of constructive personality change largely stalled. As a result, few studies have been able to model Rogers' relational and process-based assumptions within a single coherent longitudinal framework. Addressing this limitation requires a research clinic specifically designed to support systematic,

repeated assessment across the course of therapy—a requirement met by the HFP.

1.4 The Human Flourishing Project

The HFP is a person-centred research clinic established in 2017 in collaboration with the Master of Arts in Person-Centred Experiential Counselling and Psychotherapy programme at the School of Education, University of Nottingham. The project began through the voluntary efforts of Professor David Murphy and members of the academic team, with the intention of creating a clinical and research environment grounded in person-centred values.

The HFP serves three interrelated aims. First, it provides trainee therapists with the opportunity to complete the 100 clinical practice hours required to graduate from the Master's programme, within a supervised environment informed by person-centred and experiential principles. Second, it offers free counselling to members of the local Nottingham community, with therapy delivered in accordance with a non-directive approach. Third, the project contributes to the person-centred literature by generating practice-based research data that capture both relational conditions and client process as they unfold within ongoing therapy.

Ethical Considerations

The HFP operates in accordance with ethical standards designed to protect clients' psychological well-being and autonomy. Clients may self-refer or be referred by public, voluntary, or private organisations. Therapy within the HFP is embedded within a practice-based research framework. As such, clients are informed at the outset that counselling at the HFP is contingent upon participation in the research component of the project, which includes

completing sessional measures and audio recording of therapy sessions. Clients who do not wish to participate in research or consent to audio recording are therefore unable to continue therapy within the HFP.

All clients attend an intake session conducted by senior therapists, during which psychological contact is established, and the aims, procedures, and requirements of the project are clearly explained. As part of this process, clients complete the C.O.R.E assessment form and receive detailed information on confidentiality, data use, and their role as research participants. Written informed consent is obtained prior to commencing therapy, confirming that clients understand the research requirements associated with participation in the HFP. Clients are informed that they may withdraw from ongoing participation in the research at any time; however, withdrawal from the research component precludes continued therapy within the HFP, and data collected up to the point of withdrawal are retained for research purposes in accordance with ethical approval.

Clients Participation

The inclusion and exclusion for HFP clients are as follows:

The HFP does not start therapy with clients if they are:

i) Actively suicidal

ii) In psychotic crisis

iii) Are a student or staff at the UoN

The HFP will continue therapy if the clients:

i. Become suicidal and or,

ii. Enter a psychosis, and in each instance additional appropriate support will be sought alongside therapy if the client wishes to continue.

Clients accepted into the project receive therapy in a block of 20-sessions and can be offered up to two blocks. The second block is not necessarily provided by the same therapist, particularly when a trainee therapist has completed the clinical hours required for graduation.

Treatment

All clients received weekly 50-minute sessions of PCT at the HFP research clinic. Therapy was delivered within a non-directive, relational framework and conducted in accordance with Rogers' three therapist conditions: empathy, unconditional positive regard, and congruence. Sessions were audio-recorded for research purposes in line with ethical approval.

Within the HFP, therapy is delivered across three treatment pathways, through which clinical outcomes are routinely evaluated under strict ethical standards:

i. Counselling for Human Flourishing,

ii. Post-Traumatic Growth,

iii. Mental Health and Trauma

Therapists

Therapy within the HFP research clinic was delivered by trainee therapists who had completed, or were in the process of completing, a UK Master's programme in Person-Centred and Experiential Counselling and Psychotherapy. Their training included formal development in empathy, congruence, and unconditional positive regard as core therapeutic conditions. Therapists

conducted clinical practice within a person-centred, non-directive framework and received ongoing supervision informed by PCT principles.

Therapists also participated in the research component of the HFP. They were informed that therapy sessions were audio-recorded for research purposes and that they were required to complete sessional documentation at regular intervals, including completing research forms every fifth session.

Client–Therapist Matching

Clients were assigned to therapists based on practical scheduling considerations rather than theoretical or clinical matching. Allocation was determined primarily by clients' preferred day and time of attendance and by therapists' availability during those periods. This procedure reflects standard practice within the HFP and ensures timely access to therapy without selective assignment based on client characteristics or presenting concerns. As a result, client–therapist pairings emerged naturally through routine service delivery rather than through experimental control.

Measures

The HFP uses two primary data collection modalities: audio recordings of therapy sessions and client-completed self-report measures. All therapy sessions were audio-recorded weekly to capture the therapeutic process. Self-report data comprised both relational and outcome measures, which were collected simultaneously. Clients completed these measures together at the beginning of selected therapy sessions. In accordance with standard HFP procedures, self-report session forms were administered at Sessions 1, 3, 5, and every fifth session thereafter, up to Session 40.

Table 1.2 List of Session Forms

Outcome Measures	Relational Measures
Authenticity Scale	Barrett-Lennard Relationship Inventory
Personal Questionnaire	Relational Depth Inventory
The Horowitz Impact of Events Scale	Client and Therapist Versions of Agnew Relationship Measure
Well-Being Scale	

Note. Outcome and relational session forms were administered at five-session intervals across therapy as part of the Human Flourishing Project protocol.

Table 1.2 presents the seven session forms routinely used within the HFP to capture clients' perceptions of the therapeutic relationship and their outcomes. These relational and outcome measures are administered at five-session intervals, allowing change to be examined across therapy (Little, 2013). Collecting relational and outcome data concurrently at each assessment point supports consistency in measurement conditions and reduces timing-related confounds (Kessler & Greenberg, 1981; Finkel, 1995; Little, 2013). This repeated measurement structure provides sufficient temporal spacing to detect effects while supporting sequential modelling of relational and outcome variables across the course of therapy, including later phases and, in some cases, up to 40 sessions.

In addition to repeated session forms, the HFP incorporates audio recordings of therapy sessions throughout treatment. Every session is recorded, enabling the examination of in-session client processes alongside self-reported relational perceptions and outcomes. This design allows process variables to be examined within a longitudinal framework, linking moment-to-moment therapeutic engagement with broader patterns of change over time.

Therefore, the HFP research design addresses key methodological limitations of the Wisconsin Project and allows the six necessary and sufficient conditions to be tested with greater precision. By using measures that more directly represent Rogers' theory of personality. Consequently, the HFP research clinic offers a solid methodological foundation for exploring the temporal assumptions embedded in Rogers' six necessary and sufficient conditions for constructive personality change (Rogers, 1957, 1959).

1.5 Conceptual Framework

This thesis adopts a theoretically constrained analytic framework grounded in Rogers' (1957, 1959) six necessary and sufficient conditions for constructive personality change. Rogers did not present the six conditions as independent variables, but as a unified set of relational and experiential requirements through which personality development may occur. The present study, therefore, prioritises conceptual coherence over analytic fragmentation. The six conditions are situated within a single relational–process-outcome framework, informed by Rogers' (1961) stages of process, and examined through temporally ordered associations.

1.5.1 Conditions 1 and 2

Condition 1 specifies that psychological contact exists between two persons, and Condition 2 specifies that the client is in a state of incongruence or vulnerability. These conditions define the *context* in which Rogers' hypothesis applies, rather than variables to be independently manipulated or measured.

In the present thesis, both conditions are satisfied by the clinical circumstances in which the research takes place. All participants were engaged in ongoing person-centred psychotherapy within the HFP. The administration of

relational measures within an active therapeutic relationship presupposes psychological contact, whereas participation in therapy itself implies at least partial incongruence. Conditions 1 and 2 are therefore treated as necessary preconditions that render the assessment of the remaining conditions theoretically meaningful, rather than as constructs requiring separate operationalisation.

1.5.2 Conditions 3 to 6

Rogers (1957) located the causal force of therapeutic change not in technique, but in the therapist's relational attitudes as *perceived by the client*. These attitudes—empathy, unconditional positive regard, and congruence—are effective only insofar as they are received and experienced by the client. The B-LRI was developed precisely to operationalise this formulation. The B-LRI directly assesses client-perceived empathy, unconditional positive regard, and congruence, thereby operationalising Conditions 3, 4, and 5. By relying on client report rather than therapist self-assessment or external observation, the instrument also operationalises Condition 6, which specifies that the three therapists' conditions must be perceived by the client. In this respect, the B-LRI aligns closely with the phenomenological and relational intent of Rogers' theory.

Administered within an active therapeutic relationship, the B-LRI allows all six conditions to be situated within a single empirical framework. Conditions 1 and 2 are embedded in the clinical context, while Conditions 3–6 are operationalised through clients' lived perceptions of the therapeutic relationship. This approach enables the study to examine Rogers' hypothesis in a manner that is theoretically coherent, empirically constrained, and faithful to the relational foundations of PCT. However, the study does not assess the three therapists' conditions independently of client perception. Observer- or therapist-rated

measures, such as the Agnew Relationship Measure (ARM; Agnew et al., 1998), may be useful for examining therapist enactment or discrepancies between intention and experience, but such questions fall outside the scope of the present design. Instruments indexing relational depth (e.g., the Relational Depth Inventory; Wiggins et al., 2012) were also considered. However, because these measures overlap conceptually with client-perceived relational quality, their inclusion would introduce redundancy and blur the distinction between relational conditions and subsequent client processes. For this reason, relational depth was not included as a separate variable in the longitudinal modelling.

1.5.3 Process Variable

Rogers (1961) conceptualised constructive personality change as a process in which a facilitative relational climate enables clients to engage more openly with their internal experience. Barrett-Lennard (1962) similarly emphasised that the quality of the therapeutic relationship is therapeutically effective only insofar as it is received and worked with experientially by the client. From this perspective, relational perception alone is insufficient; it must be accompanied by a process that attends to, symbolises, and integrates experience over time. This experiential process is operationalised in the present thesis using the Clients' Experiencing Scale (EXP; Klein et al., 1986). The EXP provides observer-based ratings of clients' moment-to-moment engagement with their felt experience during audio-recorded therapy sessions. It indexes the manner in which clients attend to, articulate, and work with inner experience as it unfolds within the quality of the therapeutic relationship. Higher levels of experiencing reflect reduced defensiveness, increased openness to experience, and greater integration between awareness and feeling. Although no instrument directly measures the OVP, the EXP offers the most conceptually proximate and

methodologically defensible operationalisation of the experiential dimension through which the AT is expressed in therapy.

The inclusion of a therapist-focused process measure was also considered. In this respect, the Person-Centred and Experiential Psychotherapy Scale (PCEPS; Freire, 2013) would, in principle, have strengthened the thesis by providing a means to check alignment between therapist delivery and client uptake and to reduce potential attribution bias in process ratings. However, reliable use of the PCEPS and EXP requires a high level of rater expertise and the simultaneous coding of therapist and client processes within the same audio material. Given the aims of the present thesis and the primary investigator's status as a beginning rater, it was methodologically preferable to focus exclusively on client process within the audio material rather than attempting to code both therapist and client processes simultaneously.

1.5.4 Outcome Variable

Optimal functioning is assessed using the Authenticity Scale (AS; Wood et al., 2008). When self-alienation and susceptibility to external influence items are reverse-scored and considered alongside authentic living, the scale indicates the individual's alignment between lived experience and self-concept. This corresponds closely to Rogers' description of optimal functioning as openness to experience, trust in the organism, and reduced reliance on external standards of evaluation. Rogers did not conceptualise optimal functioning as a fixed endpoint, but as a way of being characterised by greater congruence. Such functioning cannot be observed directly; it is inferred through how individuals relate to and evaluate their experience. In the present thesis, authenticity is therefore treated as an indicator of later-level congruence within therapy, rather than as a measure of change per se. Although authenticity may also be understood as a

process within Rogers' theory, it is used here as an outcome-level indicator during the later phases of therapy.

Alternative outcome measures were considered. The Scale of General Well-Being (SGWB; Longo, Coyne, & Joseph, 2017) was available within the wider HFP dataset; however, the number of participants with complete longitudinal data on this measure was insufficient for inclusion in the present analyses. Measures explicitly designed to operationalise Rogers' concept of the fully functioning person, such as the Strathclyde Inventory (Freire, 2007), were also considered. However, this instrument was not embedded within the HFP dataset and could not be introduced retrospectively within a secondary analysis. The AS was therefore retained as the most theoretically congruent and methodologically viable indicator of later-level functioning available for longitudinal modelling in the present thesis.

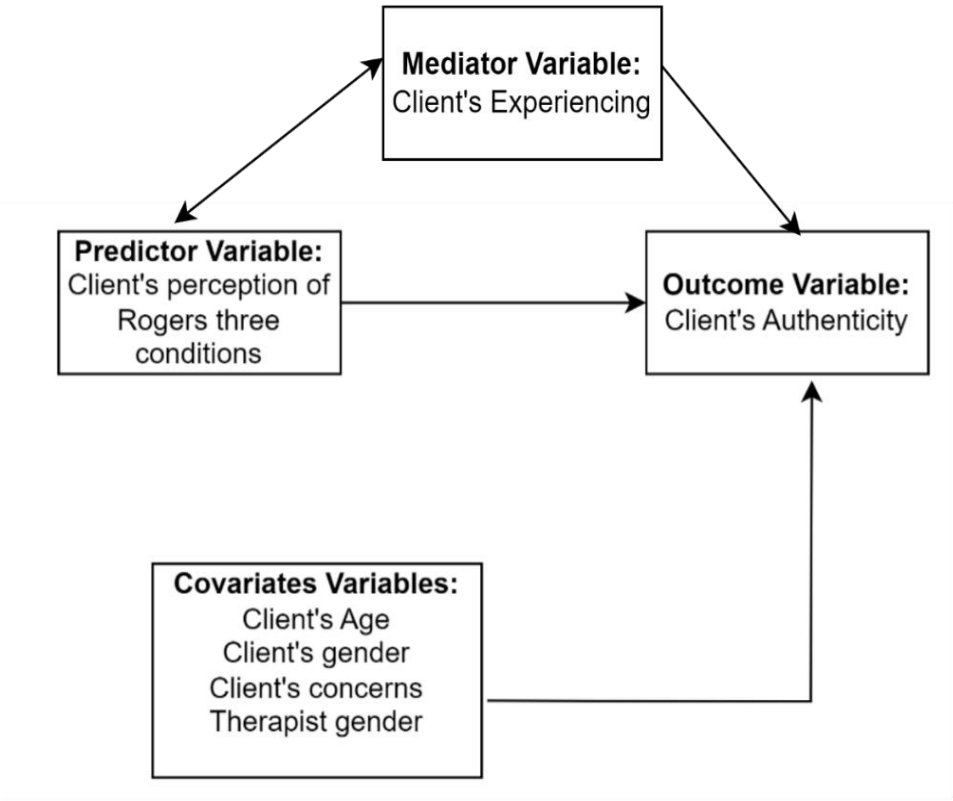
In summary, empirical testing of Rogers' hypothesis necessarily relies on theoretically grounded proxy measures that stand in for core components of the proposed pathway. Michell (1997, 2020) suggested that psychological measurement is only meaningful when the attribute being studied has a quantifiable structure. Similarly, Cai (2012) pointed out that latent psychological attributes cannot be directly observed and must be inferred from valid indicators. These conditions are satisfied by the B-LRI, the EXP, and the AS. Together, these instruments enable the six conditions, a process stage, and an outcome to be depicted as continuous psychological attributes appropriate for longitudinal analysis. By modelling these variables longitudinally, the thesis addresses Watson's (1984) plea for quasi-experimental methods that can specify temporal ordering.

1.5.5 Temporal Design

This thesis performs a secondary analysis of the HFP database, employing the cross-lagged panel design (CLPD; Kenny, 1975) and mediation analysis to examine the sequence of events across time. Collins (2006) highlighted that longitudinal analysis is most insightful when it follows a theoretically established order. Rogers' (1959, 1961) hypothesis offers such an order by placing the client's perception of the therapist's relational conditions at the core of the therapeutic process, emphasising that these conditions must be perceived and accepted by the client. These six conditions create the initial relational context for therapy. The client's experience of this context indicates how it is internalised and engaged with on an experiential level, which eventually influences levels of authenticity.

As illustrated in Figure 1.2, clients' perception of the three therapists' conditions and the client's experiencing are understood as mutually influencing processes rather than as a simple unidirectional pathway. Clients' perceptions shape how they engage with their inner experience, while their manner of experiencing also informs how the quality of the therapeutic relationship is received and symbolised. Authenticity is treated as an indicator of the client's level of congruence at later stages of therapy, reflecting the person's alignment with experience. In this way, the analytic strategy remains consistent with Rogers' relational theory while allowing the temporal structure of these processes to be examined empirically.

Figure 1.2 Conceptual Framework



Horizon. The study adopted a longitudinal, not a cross-sectional, approach, in which observations are made multiple times within the HFP database.

Unit of analysis: The study aimed to understand the potential outcome of therapy. Therefore, the level of analysis was the individual.

Study setting: The study aimed to examine the research variables in a clinical setting.

Figure 1.1 provides the conceptual framework within which the mediation model is situated. PCT is located at the intersection of relational helping, the meta-theory of the AT, and optimal functioning. The mediation model operationalises this intersection by specifying a directional pathway in

which clients' perceptions of the three therapists' conditions (relational helping) are associated with later authenticity (optimal functioning), with experiencing representing the client-level process through which the AT becomes expressed and organised in therapy.

However, it is important to note that Figure 1.2 does not test two central aspects of Rogers' (1957, 1959, 1961) hypothesis. First, the model cannot evaluate necessity. Rogers defined the therapist's conditions as necessary in the sense that constructive personality development does not occur in their absence. Neither mediation analysis nor cross-lagged panel modelling can examine such counterfactual conditions. The present analyses, therefore, compare relatively higher and lower client perceptions of the therapist's conditions, testing sufficiency only in probabilistic terms rather than indispensability. Second, the model does not represent constructive personality change as a within-person movement from incongruence to congruence. Although authenticity is measured repeatedly, the CLPD estimates temporal ordering between earlier and later levels across individuals, rather than modelling individual developmental change. Constructive personality change is thus represented as directional association rather than movement from incongruence to congruence. In this sense, the mediation analysis does not test the full theoretical proposition but examines one empirically tractable pathway embedded within the broader person-centred framework.

1.6 Research Objectives

This thesis is guided by three interrelated premises. First, Rogers' (1957) six necessary and sufficient conditions are theoretically interdependent: therapist attitudes cannot be facilitative in the absence of psychological contact and client incongruence, and they exert their effects only when perceived by the

client. Second, if constructive personality change is relationally grounded, the client's phenomenological perspective must therefore be central when testing Rogers' (1959) hypothesis. Third, because Rogers (1961) conceptualised therapeutic development as a process unfolding over time, a longitudinal process design is required to establish temporal order and plausible directional influence.

On this basis, the overarching aim of the thesis is to test the temporal direction by examining how six necessary and sufficient conditions, experiential process, and authenticity are associated over time within the HFP. To achieve this aim, the study pursues a sequence of interrelated objectives that build cumulatively toward a single longitudinal model.

First, the study undertakes a systematic review of empirical research using the B-LRI to examine how Rogers' six conditions have been operationalised and tested over time. This review specifically evaluates whether existing B-LRI findings genuinely test Rogers' necessary and sufficient conditions as an integrated, relational hypothesis, or whether they reflect a narrowed interpretation shaped by historical and methodological constraints. In doing so, the review identifies a recurring empirical pattern in which client-perceived therapist conditions are positioned early in the therapeutic process and examined in relation to later outcomes, while also highlighting the absence of models that integrate process variables within this temporal sequence.

Second, building directly on this literature, the study tests the temporal direction of the relational pathway identified in prior work. Bayliss-Conway et al. (2021) reported that clients' early perceptions of the therapeutic relationship at Session 5, as measured by the B-LRI, were positively associated with higher levels of authenticity at Session 10, as assessed by the AS. By capturing client perceptions of empathy, congruence, and unconditional positive regard early in therapy and examining authenticity later, this design provides initial support for

Rogers' assumption that the relational climate experienced by the client precedes developmental movement. The present study seeks to replicate this temporal association and to provide a stronger test of directional ordering using longitudinal modelling approaches such as the cross-lagged panel design (Kenny, 1975; Selig & Little, 2012).

Third, the study extends this pathway by integrating a theoretically grounded process variable. Specifically, it examines how client experiencing operates within the temporal sequence linking early client-perceived therapist conditions to later authenticity. By incorporating in-session ratings of experiencing alongside self-reported relational and outcome measures, the study tests whether therapist conditions, as perceived by the client, are associated with later experiential engagement and whether this process, in turn, is linked to subsequent levels of authenticity. In this way, the research expands existing temporal models by examining not only whether early relational perceptions precede later outcomes, but how this relational influence may be taken up experientially within therapy.

Therefore, these objectives allow the present study to move beyond isolated associations and toward a theoretically faithful test of a central temporal pathway within Rogers' hypothesis, while remaining explicit about the limits of what can be operationalised within a longitudinal quantitative design.

Hypothesis (H_1):

Clients who perceive higher levels of the three therapists' conditions earlier in therapy will be more likely to show higher levels of authenticity later in therapy through their capacity to engage with and experience the therapeutic process at the mid phase, compared with clients who do not.

Null hypothesis (H_o):

Clients who perceive higher levels of the three therapists' conditions earlier in therapy will not be more likely to show higher levels of authenticity later in therapy through their levels of experiencing at the mid phase, compared with clients who do not.

1.7 Significance of the Project

This thesis contributes to person-centred psychotherapy research by offering a theory-consistent way of examining Rogers' six necessary and sufficient conditions as a unified relational proposition. Its significance lies in re-aligning empirical investigation with Rogers' original causal logic, rather than fragmenting the conditions into isolated variables or outcome-driven associations. At a theoretical level, the study clarifies how the six conditions may be understood and examined as an integrated relational configuration grounded in client perception and psychological contact. By preserving this internal coherence, the thesis addresses a longstanding difficulty in the empirical literature, where Rogers' hypothesis has often been tested in ways that depart from its original formulation. At a research level, the project provides a structured framework for linking relationship quality, experiential process, and later authenticity within a longitudinal design. This shifts the focus from static associations between clients' perceptions of the three therapists' conditions and outcomes to the temporal organisation of relational and experiential variables, supporting more developmentally informed process research.

The project holds particular importance in its epistemic perspective. PCT considers clients' perceptions, emotions, and narratives as the main sources of knowledge, rather than secondary signs of change. By prioritising the client's viewpoint, the thesis supports person-centred inquiry methods that focus on

subjective meaning rather than standardised symptom measures. This perspective endorses research practices that view clients as experts on their own experiences, increasing the ecological validity and interpretive significance of person-centred studies. More broadly, the project establishes a foundation for future person-centred research that engages with Rogers' personality theory as a relational and developmental system. It offers a template for cumulative longitudinal investigation that remains conceptually faithful while empirically tractable, thereby supporting more precise and theoretically grounded progress in the field.

Therefore, the thesis demonstrates how Rogers' hypothesis can be empirically examined without assuming deterministic causation or requiring the full operationalisation of all theoretical elements. By identifying and testing a theoretically central relational pathway, the study clarifies which empirical claims can—and cannot—be made regarding necessity, sufficiency, and therapeutic development.

1.8 Overview of the Thesis Structure

The PhD is structured in nine chapters, each contributing a distinct part of the argument. Together, they provide the theoretical, methodological, and empirical basis for testing Rogers' hypothesis of the six necessary and sufficient conditions. The chapters are organised as follows:

Chapter 2: The Barrett-Lennard Relationship Inventory in Theory and Practice: A Systematic Review to test Rogers' Six Necessary and Sufficient Conditions. This chapter presents a systematic review of studies that have used the B-LRI to investigate Rogers' six necessary and sufficient conditions for constructive personality change. It explores how researchers have used the B-LRI to evaluate the six conditions within a single integrated model and what existing

evidence suggests about the significance of these perceptions at the outset of the therapeutic process. It also identifies what remains untested, thereby providing a crucial evidence base for the subsequent analyses.

Chapter 3: Experiencing, Authenticity, and the Process of Therapeutic Personality Change. This chapter examines authenticity as a process-outcome construct for testing Rogers' hypothesis. It then examines the Experiencing Scale as a measure of clients' receptivity to experience and their manner of engaging with felt meanings in sessions. Together, these constructs frame an analytic examination of how clients' manner of experiencing within therapy may operate within the relational process to support movement toward constructive personality growth.

Chapter 4: Methodology: A Longitudinal Examination of Rogers' Sequential Model of Constructive Personality Change. This chapter adopts a post-positivist position and sets out the rationale for using cross-lagged panel modelling to examine whether clients' perceptions of the therapist's conditions temporally precede later levels of experiencing and authenticity, in line with Rogers' view of personality development as a process guided by the actualising tendency. The chapter then details the measures, the procedure for rating audio recordings, the sampling approach, data preparation, and the analytic strategy used to examine this sequential pathway.

Chapter 5: Principal Component Analyses of the B-LRI and AS. This chapter reports principal component analyses to examine the factor structure of the B-LRI and AS. Findings inform whether these instruments should be treated as observed or latent variables, shaping the design of later analyses.

Chapter 6: Pilot Study: Assessing the Feasibility of Longitudinal Modelling of Rogers' Six Necessary and Sufficient Conditions. This chapter presents a pilot

study examining whether client perceptions of the therapist's conditions and authenticity display coherent temporal associations across therapy. It evaluates whether these patterns support longitudinal modelling and reports an initial four-wave cross-lagged panel analysis. The findings inform refinement of the longitudinal modelling strategy used to examine Rogers' hypothesised sequential pathway in subsequent analyses.

Chapter 7: Early Client Perceptions of Rogers' Three Therapist Conditions and Later Authenticity: A Cross-Lagged Panel Correlation Analysis. This chapter presents the results of a two-wave cross-lagged panel analysis examining whether clients' early perceptions of the three therapists' conditions are associated with later levels of authenticity. The findings are interpreted in relation to Rogers' hypothesised sequential pathway and provide a foundation for introducing a third process variable in subsequent analyses.

Chapter 8: The Role of Client Experiencing in Mediating Early Perceptions of Rogers' Three Therapist Conditions and Later Authenticity. Mediating Role of Client Experiencing. This chapter introduces client experiencing as a process variable for examining the relationship between clients' perceptions of the therapist's conditions and authenticity. It evaluates alternative representations of experiencing and examines its role within a mediation framework, alongside complementary analytic approaches, to assess how experiencing functions within the testing of Rogers' hypothesis.

*Chapter 9: General Discussion and Conclusion***.** This chapter synthesises the thesis's key findings in relation to Rogers' six necessary and sufficient conditions for constructive personality development. The results are evaluated in terms of their support for, refinement of, and challenges to Rogers' hypothesis when examined longitudinally. The chapter then considers the theoretical and practical implications for PCT, with particular attention to the role of client-

perceived therapist conditions and experiential processes. Study limitations are critically reviewed, and directions for future research are proposed to strengthen the empirical testing of the six necessary and sufficient conditions. The chapter concludes by situating the thesis's overall contribution to advancing and refining Rogers' relational hypothesis.

Chapter 2: *The Barrett-Lennard Relationship Inventory in Theory and Practice: A Systematic Review to Test Rogers' Six Necessary and Sufficient Conditions*

2.1 Introduction

Early empirical work in the 1960s is often cited as evidence that Rogers' three therapists' conditions are necessary but not *sufficient* for constructive personality change. This claim has shaped how Rogers' hypothesis has been interpreted in the field of psychology. However, this conclusion rests on a fundamental methodological question: *what exactly was tested?*

Studies conducted during this period relied almost exclusively on the Carkuff and Truax scales developed within the Wisconsin Schizophrenia Project (1957–1963), including the Accurate Empathy Rating Scale, the Therapist Genuineness (Congruence) Scale, and the Unconditional Positive Regard Scale (Truax & Carkhuff, 1967; see also Truax, Wargo, & Silbert, 1966). These scales assessed therapists' conditions (Conditions 3–5) through observer ratings. As a result, Condition 6— *"that the client perceives, at least to a minimal degree, conditions 4 and 5; that the communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved"* (Rogers, 1957)—was not operationalised. This methodological choice creates a clear mismatch with Rogers' hypothesis. By omitting Condition 6, early studies fragmented the six-condition model and examined only selected components of the hypothesis rather than the relational sequence Rogers proposed.

The introduction of the Barrett-Lennard Relationship Inventory (B-LRI) marked a turning point in attempts to realign empirical testing with Rogers' original theoretical assumptions. Unlike earlier observer-based instruments, the B-LRI is designed for use within a real therapeutic relationship (Condition 1) with psychologically vulnerable and incongruent clients (Condition 2). It assesses how clients perceive the therapist's congruence, empathic understanding, and unconditional positive regard, thereby directly operationalising Conditions 3 through 6. By locating the relational conditions within the client's lived experience, the B-LRI preserves the phenomenological grounding of Rogers' hypothesis and allows the six conditions to be examined as an integrated relational process.

Empirical comparisons reinforced the necessity of a shift from observer-rated instruments to client-perception measures when testing Rogers's hypothesis. Across multiple direct comparisons, the Accurate Empathy Rating Scale, the Therapist Genuineness (Congruence) Scale, and the Unconditional Positive Regard Scale showed little convergence with B-LRI and weak or inconsistent associations with therapeutic outcome, whereas B-LRI were reliably linked to outcome (Caracena & Vicory, 1969; Gurman, 1977; McWhirter, 1973; Truax & Carkhuff, 1967; Whiston & Sexton, 1993). Consistent with these findings, Parloff et al. (1978) identified client perception of the therapeutic relationship as the clearest and most reliable predictor of outcome. These findings indicate that the Truax and Carkhuff scales and the B-LRI assess different components of the therapeutic relationship, thereby limiting the extent to which results derived from observer-based measures can be treated as tests of Rogers' hypothesis.

Lockhart (1984) and Watson (1984) noted that studies relying on the Accurate Empathy Rating Scale, the Therapist Genuineness (Congruence) Scale, and the Unconditional Positive Regard Scale selected therapist variables rather

than the six conditions as an integrated relational sequence. None of the early studies in the 1960s assessed all six of Rogers' conditions within a single relational model. Research focused almost entirely on therapist attitudes (Conditions 3–5), neglected real psychological contact (Condition 1), failed to assess client incongruence (Condition 2), and rarely examined client perception over time (Condition 6). Without these elements, the proposed causal sequence cannot be tested. Although a substantial body of findings now exists on empathy, congruence, and unconditional positive regard, claims that the six necessary and sufficient conditions are "not sufficient" reflect a misinterpretation of the evidence, as the hypothesis was never empirically examined in the form in which it was originally proposed.

This gap has generated ongoing uncertainty about whether the six conditions operate together as a relational pathway predicting movement toward authenticity. Early methodological tendencies—observer ratings, abbreviated subscales, cross-sectional correlations, and analogue designs—fragmented the theory (See Watson, 1984). Analogue studies using student participants cannot test Rogers' hypothesis, as they make it impossible to meet the prerequisites of real psychological contact and genuine incongruence (e.g. Cramer, 1988). Without an authentic therapeutic relationship, Conditions 3–5 cannot be meaningfully delivered or perceived, and no psychological movement can be observed for Condition 6.

As a result, it remains unclear whether literature has ever tested Rogers' six conditions as an integrated relational sequence, or whether the same conceptual and methodological limitations persist in later research. This uncertainty establishes the necessity of the present chapter. Accordingly, this chapter provides a systematic review of empirical studies using the B-LRI to examine Rogers' (1957, 1959) hypothesis of the six necessary and sufficient

conditions for constructive personality change. Guided by PRISMA 2020, the review evaluates how the B-LRI has been used in research practice and whether these applications genuinely test the six-condition hypothesis as Rogers formulated it. Eighteen studies met the inclusion criteria. The findings establish the empirical and methodological foundation for the present thesis and directly inform the longitudinal modelling adopted in subsequent chapters.

2.2 The Barrett-Lennard Relationship Inventory

The B-LRI consists of four parallel forms, each capturing a different perspective on the therapeutic relationship: the client's perception of therapists' three conditions (Other-to-Self; B-LRI-OS), the therapist's self-assessment, the therapist's perception of how the client views them (Myself-to-Other; B-LRI-MO), and an observer's rating of therapists' three conditions (Observer; B-LRI-Obs). Among these forms, the OS is the most relevant to test Rogers' hypothesis. It directly captures how the client perceives the therapists' three conditions. Therapist self-reports, third-party evaluations, and other measurement tools repeat the limitations of earlier studies. As they do not capture the relational climate from the client's internal standpoint, they are less suited to testing Rogers' six necessary and sufficient conditions.

This distinction is supported by the broader empirical literature. Across major quantitative syntheses of Rogers' therapist conditions, client-perceived relational variables show reliable associations with psychotherapy outcome, with the B-LRI—particularly the B-LRI-OS—emerging as the most theoretically aligned measure. Elliott et al. (2018) report that therapist empathy is associated with outcome ($r = .28$), with client-rated empathy outperforming observer- and therapist-rated measures and explicitly identify the B-LRI-OS as an operationalisation of Rogers' hypothesis. Farber et al. (2019) similarly report a

positive association between therapist positive regard and outcome (r ≈ .28), with stronger effects when client-rated B-LRI scores are used. Kolden et al. (2011) report a consistent association between therapist congruence and outcome (r = .23), with client-rated congruence yielding larger effects (r ≈ .29) than ratings derived from B-LRI-MO or B-LRI-Obs. These findings indicate that client perception, as captured by the B-LRI-OS, is the empirically supported locus of the therapeutic relationship.

The B-L RI other to self (OS) has been modified many times since its first publication; The original 85-item version comprised five subscales—Empathy, Level of Regard, Unconditionality, Congruence and Willingness-to-be-Known, but the Willingness subscale was later dropped and its items absorbed into Congruence (Barrett-Lennard, 1978, 1986). Its length was reduced from 92 to 85 items (Barrett Lennard, 1962), then to 72 items, and finally to 64, 40, and 12 items. Although the 64-item versions of the B-L RI were significantly shorter than its first version, researchers still considered the B-L RI lengthy and suggested further reduction based on the results of exploratory factor analysis (Cramer, 1986; Gurman, 1977; Wiebe & Barnett Pearce, 1973). Shorter versions (40- and 12-item) were later introduced to reduce respondent burden (Barrett-Lennard, 2002, 2003; Chen et al., 2021).

Psychometric evaluations of the B-LRI-OS-64 demonstrate strong reliability and validity across settings. Internal consistency for the four subscales is typically high (Cronbach's α around .78–.91), and short-term test–retest reliability is usually between .70 and .80 (Barrett-Lennard, 1986, 2015). Factor analyses generally recover the intended four-subscale structure, although overlapping between Unconditionality and Level of Regard produces weaker or cross-loadings (Blatt et al., 1996; Ganley, 1989). Psychometric studies of the B-LRI: OS-40 support its reliability. Reported mean alpha coefficients are 0.85 for Level

of Regard, 0.89 for Empathy, 0.82 for Congruence, 0.76 for Unconditionality, and 0.92 for the total scale (Barrett-Lennard, 2002). These values demonstrate strong internal consistency for both the subscales and the global measure.

2.2.1 B-LRI Description

The B-LRI OS versions—both the 64- and 40-item forms—contain four subscales: Level of Regard (LOR), Empathy (E), Unconditionality (U) and Congruence (C). E measures how well clients feel their therapist understands and relates to their emotions; U evaluates the extent to which clients feel unconditionally accepted; LOR assesses whether clients feel held with care and positive regard; and C captures whether therapists are perceived as genuine in the therapeutic relationship. Together, these four subscales provide a comprehensive assessment of the client's experience and allow researchers to examine whether these relational factors predict therapeutic outcomes (Elliott et al., 2018; Murphy & Cramer, 2014).

Clients rate their perception of the therapist's conditions on a 6-point bipolar scale ranging from –3 (strongly feel that it is not true) to +3 (strongly feel that it is true). Each B-LRI: OS-40 subscale comprises 10 items, with five positively worded and five negatively worded statements (See Appendix 1).

Table 2.1 presents one example of either a positively or a negatively worded item from the B-LRI: OS-40. Negatively phrased items assess disruptions in key relational qualities, such as item 14 in E ("My therapist's feelings or attitude tend to get in the way of understanding me") and item 40 in C ("I believe that my therapist has feelings s/he does not tell me about that affect our relationship"). They may also reduce acquiescence bias by encouraging respondents to consider both positive and negative aspects of therapy. In this way, negatively worded items broaden the measurement of the relational

climate by capturing not only the presence of the therapist conditions, but also their perceived absence or obstruction.

Table 2.1 Example Items for the B-LRI

Subscale	Example items
Level of Regard	"I feel friendly and warm toward my therapist." (Item 29)
Empathy	"My therapist's feelings or attitude tend to get in the way of understanding me." (Item 14)
Unconditionality	"Whether thoughts or feelings I express are 'good' or 'bad' makes no difference to my therapist's feelings toward me (item 27)
Congruence	"I believe that my therapist has feelings s/he does not tell me about that affect our relationship." (Item 40)

Notes. Example of items for each B-LRI subscale.

Scores for each subscale range from –30 to +30 and are summed to produce a global score. This global score represents the client's overall perception of the therapeutic climate. As Lietaer (1984) noted, the four B-LRI subscales together reflect the Rogerian *facilitative relationship* as an interdependent relational climate rather than as separable therapist behaviours. Higher global scores, therefore, indicate that the client perceived stronger levels of empathy, congruence, and unconditional positive regard, reflecting a more facilitative therapeutic climate and closer alignment with Rogers' relational conditions rather than distinct ratings of separate subscales.

2.3 Objectives

2.3.1 Primary Objective

The present systematic review follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Page et al.,

2021). Its primary aim is to assess whether research using the B-LRI has ever tested Rogers's six necessary and sufficient conditions as a single, interdependent and sequential relational model. Watson (1984) argued that the full set of conditions had never been evaluated together, and this review examines whether later studies have addressed this gap.

Using PRISMA is essential in this context because the B-LRI literature is diverse and often inconsistent. PRISMA provides a transparent structure for reporting how studies were identified, screened, and selected. Examining how previous studies have designed and implemented the B-LRI clarifies what has been tested, what has been overlooked, and whether the existing evidence speaks to Rogers's original causal pathway.

2.3.2 Secondary Objectives

In support of the primary aim, this review addresses three secondary objectives:

i. **Assess completeness and fidelity**: To examine whether the B-LRI has been used in ways consistent with Rogers's six necessary conditions as an integrated construct, or whether modifications have compromised theoretical validity.
ii. **Analyse outcomes**: To explore associations between B-LRI scores and therapeutic effectiveness across diverse settings and populations, and to review what the literature already shows about temporality. This includes examining whether studies measured the B-LRI early in therapy, assessed outcomes at later points, and tested the direction proposed by Rogers. The review evaluates whether higher early B-LRI scores have been linked to later improvement, and whether such patterns appear across different client groups. In doing so, it assesses the extent to which past research

provides evidence for the temporal pathway in which early perceived conditions precede later experiencing or authenticity.

iii. **Identify gaps**: to highlight methodological and theoretical limitations that have prevented a robust test of Rogers' hypothesis, and to inform future directions such as longitudinal and causal modelling.

2.3.3 PICO/PECO Framework

The research questions are structured using PICO/PECO to make the review transparent and replicable:

Population (P): Studies involving clients in PCT, or studies explicitly assessing therapist–client relationships.

Intervention/Exposure (I/E): Use of the B-LRI to measure client perceptions of therapist conditions.

Comparison (C): Comparisons were based on the outcome scale used in each study and the study design, distinguishing between cross-sectional and longitudinal approaches.

Outcome (O): The B-LRI's effectiveness in predicting positive therapeutic outcomes such as symptom reduction, increased authenticity, or reduced alienation.

Research Question:

To what extent has the B-LRI been used to test Rogers' hypothesis that the six conditions lead to constructive personality change, and what evidence exists that client perceptions of therapist conditions predict later therapeutic outcomes?

2.4 Methodology

This review was conducted in accordance with the PRISMA 2020 guidelines (Page et al., 2021), which provide a structured framework for reporting systematic reviews. The methods were planned to maximise transparency and reproducibility while maintaining close alignment with the theoretical question: whether studies using the B-LRI have provided a true test of Rogers' six necessary and sufficient conditions for constructive personality change.

2.4.1 Search Strategy and Databases

The search was carried out in two stages. First, a structured search was conducted across four electronic databases: PubMed, PsycINFO, and ScienceDirect (Elsevier). These were chosen to cover clinical psychology, psychotherapy, psychiatry, and broader health sciences.

The following Boolean search string was applied, adapted to the indexing terms of each database:

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("Barrett-Lennard Relationship Inventory" OR "B-LRI")
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Medical Subject Headings (MeSH) and PsycINFO thesaurus terms were used where available. The search was limited to peer-reviewed journal articles in English, published between 1964 and May 2025, to capture both foundational and contemporary applications of the B-LRI.

In the second stage, reference lists of all included studies were hand-searched to identify additional eligible papers not captured in the database searches.

2.4.2 Inclusion and Exclusion Criteria

Inclusion criteria were applied to studies that operationalised all six necessary and sufficient conditions, linked these conditions to an outcome variable, and assessed the therapeutic relationship from the client's perspective. These studies include:

i. Studies that explicitly use one of the two B-LRI-OS versions (B-LRI-OS64 and B-LRI-OS40) to assess clients' perception of the quality of the therapeutic relationship.

ii. Studies that use quantitative research design (e.g. Secondary analysis of a randomised controlled trial (RCT) dataset or pre-post design).

iii. Studies including populations of clients receiving psychotherapy from different therapeutic approaches.

iv. Studies that reported measurable outcomes on therapeutic relationships, process, or client change.

v. Studies that are peer-reviewed and published in English.

Exclusion criteria were applied to studies when they did not assess the six necessary and sufficient conditions as an integrated set, or if they fragmented one or more conditions by examining them in isolation or failed to examine the six necessary and sufficient conditions in relation to an outcome variable. This study excludes:

I. Commentaries, theoretical papers without empirical data, editorials, dissertations, or conference abstracts.

II. Analogous studies outside psychotherapy (e.g., university settings or hospital settings)

III. Studies using only a subset of the B-LRI (e.g., empathy items only), without full subscale application.

IV. Studies using the B-LRI-MO and B-LRI-obs versions

v. Qualitative studies or descriptive studies.

2.4.3 Quality and Risk of Bias Assessment

Two JBI appraisal tools were used in this review to assess the quality and risk of bias assessment for each study. Appendix 2 presents the JBI Critical Appraisal Checklist for Systematic Reviews and Research Syntheses (Aromataris et al., 2015), which was applied to all review articles identified during screening. This 11-item checklist was used to assess whether secondary sources demonstrated clarity in their research question, appropriateness of inclusion criteria, and methodological rigour in their review process.

To complement this systematic review appraisal, Appendix 3 presents the JBI Checklist for Quasi-Experimental Studies (Barker et al., 2024), which was used to evaluate the quantitative aspects of the included studies regarding outcome assessment. This 9-item checklist focuses on group comparability, consistency of treatment delivery, repeated outcome measurement, adequacy of follow-up, and the reliability of the measures used. It was applied to non-randomised studies and RCTs that employed correlational, regression, mediation, or cross-sectional designs. The items derived from Appendix 3 were used to assess the risk of bias for each included quantitative study. Each of the 9 JBI items was rated as *Yes*, *No*, *Unclear*, or *Not applicable (N/A)*. *Unclear* ratings indicated insufficient information to judge whether the criterion had been met, while *N/A* indicated that the criterion was not relevant to the study design.

Based on the overall ratings of items across the nine items, each study was independently evaluated by the reviewer using a customised appraisal template and classified as having a low, moderate, or high risk of bias. Studies rated as low risk met most key JBI criteria and demonstrated no major methodological weaknesses likely to threaten the credibility of the findings. Moderate-risk

studies met several criteria but contained areas of uncertainty or incomplete reporting that could influence interpretation, although not to an extent that invalidated the results. High-risk studies failed to meet multiple criteria or demonstrated clear methodological problems—such as unclear randomisation procedures, substantial baseline differences, unreliable outcome measures, or significant attrition—that were likely to distort the interpretation of the findings.

Data extraction followed a structured template created for this review. Extracted variables included:

i. Study identifiers (author, year, country).
ii. Study design and sample characteristics.
iii. Version of the B-LRI used and subscales reported.
iv. Pre-post design and sample characteristics
v. Outcomes measured (e.g., authenticity, symptom reduction, therapeutic progress).
vi. Key findings, including effect sizes, were reported.

All extracted data were tabulated and cross-checked to ensure consistency. A narrative synthesis was then developed, integrating study-level findings into broader patterns related to Rogers' six conditions. Where a study reported data outside the scope of this review, which assessed both *supervisory* and *therapeutic* relationships, only the therapeutic relationship findings were extracted (e.g. Bell et al., 2016). This makes sure that the synthesis remains focused on testing Rogers' six necessary and sufficient conditions for constructive personality change.

2.5 Results

2.5.1 Search Results

The initial database search identified 174 journal article records across PubMed (N=31), APA PsycINFO (N=60), ScienceDirect (N=47), and additional studies were located through reference and citation lists (N=36). After removing 2 duplicates, 172 titles and abstracts were screened. Of these, 152 records were excluded because they did not meet the review's aims (e.g., analogue study, using only the empathy scale, or only referencing the scale). A total of 20 full-text articles were retrieved for detailed assessment. Following application of the inclusion and exclusion criteria, two studies were excluded for misusing the B-LRI. Arachtingi and Lichtenberg (1999) used the B-LRI without the congruence scale only to compute therapist–parent similarity indices, and Petry and Thomas (1986) used client B-LRI scores to compare therapists' sex-role classifications as a training measure. Neither study assessed the relationship between B-LRI scores and therapeutic outcome, and therefore, they do not test Rogers' six conditions. This process resulted in 18 studies being eligible for inclusion. The process is summarised in Table 2.2 as well as in the PRISMA 2020 flow diagram in Appendix 4; Figure 4A.

Table 2.2 PRISMA Information for Search Strategy

Stage	Studies Included	Studies Excluded	Notes
1. Search results	174	7	No relation to Barret-Lennard
2. Abstract screening	167	20	Not testing the Rogerian hypothesis, only references
3. Eligibility	147	2	Duplicates
4. Psychometric Related	145	10	Factor Analysis Studies
5. Analogue Studies	135	59	Educational program, medical and group settings (e.g. marital). Those studies do not assess condition 1
6. Partial B-RLI	76	52	2 articles used only UPR items, the rest used only empathy items. Those studies do not assess conditions 3 to 5
7.Use B-LRI-Obs	24	4	Those studies do not assess condition 6
8. No Outcome Variable	20	2	-
9. Total	18	–	–

Note: Date of search: 20 March 2025

Of the 18 studies in Table 2.3, several broad patterns emerge in how the B-LRI has been used to examine Rogers' hypothesis. Samples ranged from 6 to 239 participants, all drawn from adult populations, and most research was conducted in Western university counselling or hospital research clinics, with a smaller number in community or training-clinic settings. Two versions of the B-LRI were employed—the B-LRI-OS-64 and the B-LRI-OS-40—with most studies using the OS-64 version and only two adopting the shorter OS-40 form. Designs included RCTs, secondary analyses, prospective cohort designs and mediation or multilevel models. Ten studies were secondary analyses from the National

Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH-TDCRP) dataset (Elkin et al., 1985), embedded within the Randomised clinical trial dataset. 9 studies relied on correlational, prospective or regression-based designs. Studies assessed the B-LRI from intake through to Session 16; however, it was most measured at Session 2 and used as a predictor variable. The outcome measures also varied, ranging from depression and anxiety indices to trauma-related symptoms and authenticity. Only 3 studies used pure PCT interventions (Barrett-Lennard, 1964; Bayliss-Conway et al.,2021; Payne et al., 2007). The remaining 15 studies were conducted in mixed-orientation, psychodynamic, CBT, IPT, behavioural, or training clinic settings. This shows that the B-LRI is used as a pan-theoretical relational measure, rather than a test of PCT specifically.

2.5.2 Risk of Bias Assessment

Table 5. A; in Appendix 5 present the item-level ratings of the JBI Checklist for Quasi-Experimental Studies, which showed a mixed pattern. Ten studies (Barnicot et al., 2014; Blatt et al., 1996; Blatt & Zuroff, 2005; Dolev & Zilcha-Mano, 2019; Elkin et al., 1999; Elkin et al., 2014; Zuroff et al., 2000; Zuroff & Blatt, 2006; Zuroff et al., 2010; Zuroff et al., 2016) were rated as low risk of bias. Seven studies were rated as moderate risk (Barrett-Lennard, 1962; Bayliss-Conway et al., 2021; Beckham, 1992; Bell et al., 2016; Keijsers et al., 1994; Kolb et al., 1985; Murphy & Cramer, 2014), and one as high risk (Payne et al., 2007).

Low-risk studies tended to employ stronger designs, including randomised and placebo-controlled conditions. All 10 papers used the same 4 TDCRP treatment conditions—CBT, IPT, imipramine with clinical management, and placebo. Although their analytic research questions differed, all relied on a common outcome set, including the Hamilton Rating Scale for Depression (HDRS),

the Beck Depression Inventory (BDI), indicators of psychological distress, social functioning, and personality vulnerabilities such as self-critical perfectionism. In these studies, the B-LRI was analysed alongside the trial's primary outcome measures to assess the quality of the therapeutic relationship, thereby reducing the risk that relationship ratings were confounded by symptom reduction. However, the TDCRP design does not constitute a direct test of Rogers' six necessary and sufficient conditions, which are formulated in relation to optimal functioning rather than symptom reduction. Although Rogers' broader theory proposes that symptom change may occur under these conditions, this mechanism is not specified within the six conditions themselves. Consequently, the contribution of these studies to testing Rogers' temporal hypothesis is indirect.

By contrast, the moderate- and high-risk studies often modelled the six necessary and sufficient conditions using designs more aligned with Rogers' approach. Most authors used the B-LRI as an early process variable and linked it to later change on a pre–post basis. The measure was typically administered between Session 1 and Session 3 and then used to predict later outcomes. However, only three studies collected the B-LRI repeatedly across therapy, allowing limited examination of temporal patterns: Barrett-Lennard (1962/2015), Bayliss-Conway et al. (2021), and Murphy & Cramer (2014). Payne et al. 2007 which was rated a high-risk study, administered the B-LRI only after therapy, fragmenting the temporal ordering of early relational processes. These eight studies frequently *infer* temporal and processual relationships between Rogers' six necessary and sufficient conditions and therapeutic outcome.

Therefore, the systematic review of the B-LRI showed that quasi-experimental designs exist, but they partially test Rogers' hypothesis; poorer-quality studies attempt to test it, but their methods are weak and do not go

beyond correlation and regression analysis. Almost no studies collected the B-LRI repeatedly or modelled temporal processes within a single model. Because almost all studies relied on client self-reports, shared-method variance remains a potential concern; however, the evidence was deemed sufficiently robust to yield meaningful insights.

2.5.3 Working with the B-LRI Instrument

Researchers have engaged with the B-LRI in varied ways, resulting in notable differences in scoring procedures and analytical use across the literature. Among the 18 included studies, all employed the B-LRI-OS form, with 16 using a global score as an index of the quality of the therapeutic relationship. However, the composition of this total varied considerably. Some authors summed all four subscales (e.g., Bayliss-Conway et al., 2021; Bell et al., 2016), others omitted subscales (e.g., Dolev & Zilcha-Mano, 2019), and some created modified totals (Beckham, 1992; Murphy & Cramer, 2014). Two studies (Barnicot et al., 2014; Payne et al., 2007) analysed the four subscales separately rather than relying on a global score. This diversity in scoring reflects continuing debate regarding the B-LRI's factor structure, particularly the role of the U items.

Cramer (1986) and Murphy (2010) argued that the B-LRI was originally designed to assess a unified relational construct, often described as the facilitative climate (Cramer, 2003; Davis et al., 2015). This position is consistent with Rogers's view that the three therapists' conditions operate together as an interdependent relational climate rather than as isolated therapist behaviours. Several authors (e.g., Cramer, 2009; Ganley, 1989; Gurman, 1977; Khandaker et al., 2002; Murphy, 2010) therefore supported the validity of an overall B-LRI score as an indicator of relationship strength.

Despite this theoretical rationale, a recurring psychometric concern emerged within the TDCRP literature: instability in the U subscale. Eight of the ten TDCRP studies excluded the 16 U items from the global score, producing shortened 48-item versions that retained empathy, congruence, and level of regard. Blatt et al. (1996) reported that E, LOR, and C yielded factor loadings above .85, whereas U loaded weakly at .49. Subsequent studies found high internal consistency for a three-subscale structure excluding U (Blatt & Zuroff, 2005; Elkin et al., 1999). Barnicot et al. (2014) similarly reported that genuineness, positive regard, and empathy predicted reductions in depression severity across the 16-week TDCRP programme, whereas U did not. Collectively, these findings suggest difficulty replicating U as originally specified in Barrett-Lennard's factor analyses (1986, 2002).

In response, many TDCRP studies adapted the B-LRI by excluding U to improve psychometric performance. While this created greater comparability within that body of research, it also moved these studies away from the full relational model proposed by Barrett-Lennard. Consequently, TDCRP findings are not directly comparable with the original B-LRI structure or with studies that retained all four subscales.

Adaptations outside the TDCRP were also evident. Keijsers et al. (1994), for example, employed a culturally adapted Dutch Relationship Inventory that removed U and introduced a negative regard scale, thereby altering the construct under investigation. In contrast, Murphy and Cramer (2014) used a 32-item version of the B-LRI-OS64 that retained all four relational conditions, including U. These contrasting approaches indicate that many studies modified the instrument in ways that prioritised local analytical aims over conceptual fidelity to Rogers's original hypothesis (1957, 1959).

Overall, the TDCRP contributes a substantial proportion of the available B-LRI literature, yet provides relatively few direct tests of Rogers's relational model as originally formulated. Although this body of work creates the impression of a robust evidence base, much of it operationalises clients' perceptions of the three therapists' conditions in ways that fall short of examining the six conditions as an integrated longitudinal process. Evidence has therefore accumulated mainly for the predictive relevance of earlier client perceptions of therapist conditions in relation to later outcomes, rather than for Rogers's full six-condition hypothesis across early, mid, and late phases of therapy.

Table 2.3: Studies of Client Perception of the Quality of the Therapeutic Relationship and Outcome Across Modalities

No.	Authors (year)	Location	Sample size	Method/Design	Outcome measure	BLRI coefficient
1	Barnicot et al. (2014).	USA	157 patients; 27 clinicians	Prospective analysis; B-LRI rated at Session 2; Multilevel regression disaggregating therapist vs patient effects	BDI & HAM-D severity across weeks 4–16; recovery at week 16	Clinician-mean genuineness: BDI β = −0.32 ($p < .01$); HAM-D β = −0.17 ($p < .01$). Positive regard: BDI β = −0.29 ($p < .01$); HAM-D β = −0.16 ($p = .02$). Empathy: BDI β = −0.21 ($p = .03$). Unconditional regard: ns.
2	Barrett-Lennard (1962/2015)	Australia	42 clients; 21 therapists	Longitudinal design: Early Relationship Inventory (RI) collected after five sessions; compared expert, non-expert, and client ratings	Personality change / functioning indices measured via an independent test battery (e.g., self-ratings, therapist ratings, external assessments)	Early RI predicts later change; expert>non-expert; only weak associations for the Wisconsin group.
3	Bayliss-Conway et. Al (2021)	UK	46 adult clients	Prospective repeated measures across 10 sessions; BLRI, RDI, ARM-5 and Authenticity Scale at S1/3/5/10	Authenticity Scale (AS) at Sessions 1, 5, 10	Higher B-LRI scores at Sessions 3, 5, and 10 were significantly associated with greater increases in authenticity over 10 sessions (r = .31, .27, .35). When controlling for RDI, only B-LRI uniquely predicted authenticity.
4	Beckham (1992)	USA	31 dropouts, 24 completers	Prospective observational design: B-LRI short form administered at intake; analysed via t-tests and discriminant function	Therapy dropout before Session 6	Trend in t-test ($p < .10$); Significant predictor in discriminant analysis ($F = 5.81$, $p < .03$)

5	Bell, Hagedorn, Robinson (2016)	USA	55 counsellors-in-training; 88 clients	Cross-sectional; MLR on OQ-45 change (S1→S5)	OQ-45 change	r = .25, *p*<.05 (client BLRI vs outcome); β = .23 (sig.)
6	Blatt et al. (1996).	USA	162 clients	RCT platform; correlational & regression (BLRI at Session 2)	Residualized change: HRSD, BDI, HSCL-90, GAS, SAS; dropout	B-LRI r's with outcomes ≈ −.15 to −.26 (better BLRI → more improvement); lower dropout for higher BLRI
7	Blatt & Zuroff (2005)	USA	80 clients; 28 therapists	Cross-study B-LRI at session 2	GAS; SAS, HSCL-90, HRSD; BDI; PERFECTIONISM; EAC; DAS	Early B-LRI significantly predicts outcome across treatments (stats by figure; p < .01)
8	Dolev & Zilcha-Mano (2019)	Israel/USA	IPT n=63, Placebo n=60	Mediation model B-LRI at intake and 16 weeks of therapy and follow up	BDI slope; ISI interpersonal involvement	Moderation (IPT only): low ISI + high B-LRI → steeper BDI improvement (Δβ=−4.02, SE=1.44, p=.006); mediation ns
9	Elkin et al. (1999)	USA	99 clients	RCT base + correlational/ANCOVA/regression on early engagement; client & therapist BLRI and VTAS at S1/S4/s8/s12 and follow up;	Early attrition; VTAS patient factor	Predicting B-LRI: ΔR^2 = .06, *p*<.05; Predicting VTAS: ΔR^2 = .14, *p*<.01; r(congruence) ≈ −.20, *p*<.05
10	Elkin et al. (2014)	USA	72 clients; 17 therapists	New Therapist Responsiveness Scale predicting BLRI/VTAS at session 2 & early termination.	BLRI, VTAS, early termination	Predicting B-LRI: Positive atmosphere B≈1.53, p=.025; Global responsiveness B≈4.85, p=.034; Neg. behaviour → worse BLRI & ↑dropout
11	Keijsers et al. (1994).	Netherland	60 clients (53 PDA, 7 PD without agoraphobia)	Standardised 12-session behavioural programme for panic disorder; assessments at Pretreatment (A1), post-treatment (A2), 2-month follow-	MI-AAL / MI-AAC; MI-PF ;NHL; ACQ, HDS, HAS.	Kendall τ correlations with outcomes were nonsignificant (τ = .01–.17). In discriminant analyses, RI-patient sometimes predicted *failure*.

				up (A3). RI was completed after Session 3 by patients and therapists.		
12	Kolb et al. (1985).	USA	55 clients	Observational study: BLRI (OS-64) collected post-treatment only; used as psychotherapy process variable in regressions	(SCL-90-R subscales + GSI), therapist-rated improvement (Discharge Summary), patient-rated improvement (Personal Evaluation)	B-LRI composite ("facilitative skills") showed: (1) negative association with improvement in paranoid symptoms when controlling therapist variables; (2) dropouts rated significantly lower BLRI than completers (F = 4.25, p = .04). No single r reported.
13	Murphy & Cramer (2014)	UK	62 Clients; 12 therapists	Correlation + HMR (baseline CORE-OM controlled); S1/S3 BLRI (client & therapist)	CORE-OM at S3; change S1→S3	r = −.26 (client BLRI vs S3), β ≈ −.22, *p*≈.03; client×therapist B-LRI interaction β ≈ −.23, *p*≈.037
14	Payne et al. (2007)	UK	N = 6 survivors of interpersonal violence;	Pilot study; (pre-post-test design) B-LRI OS-64 completed post-therapy only, toward the group facilitators. Client-centred psychoeducational groups (8–10 weeks)	B-LRI;CIOQ; C.O.R.E.; IES	Participants who perceived empathy, regard, and congruence showed greater positive psychological change and reduced distress. Those who did not perceive the core conditions showed little or negative change. Higher B-LRI scores (especially empathy) Predicted greater reductions in posttraumatic stress
15	Zuroff et al. (2000)	USA	149 clients	Mediation/moderation (BLRI, VTAS; DAS Perfectionism) at session 2 and termination phase	BDI, HRSD, DAS; The Need for Approval and Perfectionism subscales	B-LRI independent predictor of outcome (exact Alliance growth mediates Perf. → outcome

16	Zuroff & Blatt (2006)	USA	191 clients	Multilevel modelling; residualised B-LRI at Session 2	BDI, HRSD, HSCL-90, GAS, SAS); EAC at follow-up	Higher early B-LRI predicted *faster symptom improvement* (B-LRI × Time: F = 11.13, p < .001) and better long-term functioning. Effects are consistent across all modalities. Alliance did not predict the outcome once B-LRI was included.
17	Zuroff et al. (2010)	USA	157 clients; 27 therapists	Multilevel; BT-BLRI / WT-BLRI × time at session 2	CMI, Self-critical perfectionism	CMI: BT-B-LRI×time F≈4.73, p<.05; WT-B-LRI×time sig.; SC-PFT: BT-B-LRI×time F≈7.60, p<.01 (r≈.25)
18	Zuroff et al. (2016)	USA	157 clients; 27 therapists	Multilevel modelling: BLRI at Session 2 decomposed into Between-Therapists (BT-BLRI) and Within-Therapist (WT-BLRI)	Composite Maladjustment Index (CMI) combining BDI, HRSD, HSCL-90, GAS, SAS	BT-B-LRI × Time: significant improvement for low perfectionism (t = –4.26); WT-B-LRI × Time: sig. improvement for high Need for Connection (t = –3.20)

*Note***.** B-LRI = Barrett-Lennard Relationship Inventory; RI = Relationship Inventory; RDI = Relational Depth Inventory; ARM-5 = Agnew Relationship Measure–Short Form; AS = Authenticity Scale; BDI = Beck Depression Inventory; HAM-D / HRSD = Hamilton Depression Rating Scale; HSCL-90 = Hopkins Symptom Checklist-90; GAS = Global Assessment Scale; SAS = Social Adjustment Scale; OQ-45 = Outcome Questionnaire-45; CORE-OM = Clinical Outcomes in Routine Evaluation–Outcome Measure; VTAS = Vanderbilt Therapeutic Alliance Scale; DAS = Dysfunctional Attitudes Scale; EAC = enhanced adaptive capacities; ISI = Interpersonal Sensitivity Inventory; CMI = Composite Maladjustment Index; GSI = Global Severity Index; SCL-90-R = Symptom Checklist-90-Revised; CIoQ = Changes in Outlook Questionnaire; IES = Impact of Event Scale; MI-AAL / MI-AAC = Mobility Inventory for Agoraphobia (Avoidance Alone / Avoidance Accompanied); MI-PF = Mobility Inventory–Panic Frequency; NHL = Nijmegen Hyperventilation List (Physical panic symptoms); ACQ = Agoraphobic Cognitions Questionnaire; HDS = Hamilton Depression Scale; HAS = Hamilton Anxiety Scale; IPT = Interpersonal Therapy;; PLA-CM = Placebo with Clinical Management; CM = Clinical

Management; RCT = Randomised Controlled Trial; HMR = Hierarchical Multiple Regression; MLR = Multiple Linear Regression; BT-BLRI = Between-Therapist BLRI; WT-BLRI = Within-Therapist BLRI; ns = non-significant; β = standardised regression coefficient; r = correlation coefficient; τ = Kendall's tau; ΔR^2 = change in explained variance; F = F-statistic; SE = standard error; S1, S3, S5, etc. = session numbers.

2.5.4 Early client-perceived relationship and later change

Across Table 2.3, early client perceptions of the three therapists' conditions consistently preceded measurable change, and this pattern aligns with Rogers's view that the client's initial experience of the quality of the therapeutic relationship shapes subsequent engagement and later improvement. When clients rated their therapists highly on the B-LRI early in therapy, their later outcomes—symptom improvement, psychological adjustment, and increases in authenticity—were more favourable. These effects emerged across CBT, IPT, clinical management, PCT, and mixed-orientation settings, suggesting that the quality of the therapeutic relationship carries predictive relevance that is not confined to a specific treatment model or client group. Because most studies collected outcome data both before and after therapy, two clear temporal pathways can be identified: (1) early B-LRI predicting early engagement, and (2) early B-LRI predicting later outcomes. Early client perceptions of the quality of the therapeutic relationship are temporally antecedent to both early engagement and later outcome.

Path 1: Early B-LRI → Client engagement

Several studies have shown that clients' early perceptions of the three therapists' conditions are associated with greater engagement in therapy (Beckham, 1992; Elkin et al., 1999; Elkin et al., 2014; Kolb et al., 1985). Within the TDCRP, Elkin et al. (1999) used the Vanderbilt Therapeutic Alliance Scale (VTAS) to assess early engagement and found that clients who experienced a better initial relational fit and therapist responsiveness exhibited higher B-LRI and VTAS scores during the early phase of therapy. Importantly, Elkin et al. (1999) further showed that clients who demonstrated more positive perceptions of the therapeutic relationship after four weeks were more likely to move toward

greater congruence over time and to remain in therapy, whereas clients in the non-congruent group showed poorer engagement and higher dropout. Elkin et al. (2014) similarly found that clients who rated their therapists as more responsive in Sessions 1 and 2 reported higher B-LRI scores and were less likely to terminate therapy prematurely. Together, these findings suggest that early perceptions of the therapists' conditions are linked not only to early engagement but also to subsequent developmental change and retention in therapy, consistent with Rogers's (1959) proposition that perceived empathic, congruent, and unconditionally accepting conditions reduce defensiveness and foster a climate conducive to active participation and growth toward congruence.

Evidence from outside the TDCRP further supports this association. Kolb et al. (1985) reported that clients who continued beyond Session 6 rated their therapists significantly higher on a composite "facilitative skills" factor derived from B-LRI items, whereas clients who dropped out showed lower early scores ($F = 4.25$, $p = .04$). Similarly, Beckham (1992) found that intake B-LRI scores significantly predicted dropout ($F = 5.81$, $p < .03$), with lower early perceptions of the therapist associated with premature termination. These findings indicate that when clients do not perceive the relational conditions as sufficiently present, disengagement and drop out from therapy are more likely to occur early in therapy. Therefore, these studies indicate that early B-LRI scores are consistently related to early engagement and continuation in therapies that place a central emphasis on the quality of the therapeutic relationship. These findings align with Rogers's theoretical account that when clients perceive the therapist as empathic, congruent, and unconditionally accepting, they become more willing to actively participate in therapy, remain engaged in the therapeutic process, and are less likely to drop out

Path 2: Early B-LRI → Later symptom or authenticity change

A consistent empirical pattern across psychotherapy research is that clients' early perceptions of the three therapists' conditions are associated with later psychological improvement. Evidence from the TDCRP illustrates that B-LRI scores, collected as early as intake or Session 2, predict subsequent reductions in depression, maladjustment, and vulnerability across CBT, IPT, and placebo conditions (Barnicot et al., 2014; Blatt et al., 1996; Blatt & Zuroff, 2005; Zuroff et al., 2006; Zuroff et al., 2016). Blatt and Zuroff (2005) further showed that clients' early perceptions of the therapeutic relationship, assessed in the second treatment session, were associated not only with symptom reduction but also with decreases in vulnerability factors such as perfectionism and need for approval, and with the later development of enhanced adaptive capacities, conceptualised as resilience. These findings suggest that early perceptions of the three therapist conditions facilitate adaptive functioning as a key process variable that shapes the trajectory of therapy toward outcome.

Similar findings have been reported in non-TDCRP settings. In person-centred training clinics, early B-LRI scores have been associated with improvements in broader personality-related constructs, including authenticity (Bayliss-Conway et al., 2021; Murphy & Cramer, 2014). Murphy and Cramer (2014) further showed that higher early perceptions of the therapeutic relationship were associated with greater treatment progress, indexed by reductions in psychological distress on the CORE-OM within the first three sessions, particularly when perceptions of the therapist's conditions were mutually high. Early relational perception has also been shown to predict short-term outcome change on global distress measures such as the OQ-45 (Bell et al., 2016) and reductions in trauma-related distress in psychoeducational group contexts (Payne et al., 2007). Foundational research further supports these findings. Barrett-Lennard (1962/2015) demonstrated that relationship inventory

scores obtained after the first five interviews were associated with later personality change across multiple perspectives. Across these studies, early B-LRI scores show a consistent predictive association with both symptom-based and growth-oriented outcomes, even after controlling for other relational variables.

However, not all studies have reported strong associations between early perceptions of the quality of the therapeutic relationship and dropout or outcome. Keijsers et al. (1994) examined the therapeutic relationship as a prognostic variable within a highly structured, exposure-based treatment for panic disorder. In this context, patient- and therapist-rated relationship scores showed weak and mostly non-significant associations with engagement and post-treatment symptom outcomes, with early B-LRI scores displaying only small and inconsistent correlations with engagement (τ = .01–.17). In multivariate analyses, patient-rated relationship quality occasionally contributed to outcome classification, but in an unexpected direction, with higher relationship ratings associated with treatment failure. In contrast, cognitive and motivational variables—particularly catastrophic agoraphobic cognitions—emerged as the most robust predictors of outcome. These findings suggest that, within intensive and highly directive exposure-based treatments for panic disorder, the quality of the therapeutic relationship may function less as an immediate facilitator of outcome and more as a background condition whose influence becomes apparent only over time or through its impact on client engagement.

Synthesis across the two pathways

Across the two pathways, the evidence aligns strongly with Rogers's model of therapeutic change. Early B-LRI scores were associated with greater early engagement in therapy—reflected in VTAS scores, session continuation and behavioural involvement—and with later improvements in symptoms, psychological adjustment and authenticity. Although the effect sizes fall within

the expected small-to-moderate range (r ≈ .15–.35), such magnitudes are typical in psychotherapy process research and represent meaningful associations. Overall, these findings indicate clients' perception of the three therapists' conditions operate as a consistent and meaningful contributor to client engagement and later psychological change, especially during the early phase of therapy.

2.5.5 Moderators and Client Factor

Table 2.3 presents six studies in which client characteristics moderated the relationship between early B-LRI scores and therapeutic outcomes. These studies show that the impact of early relational perception is not consistent across all clients but varies depending on clients' internal states, interpersonal tendencies, and patterns of early engagement. Instead of a single linear pathway, the findings suggest a diverse set of client factors that influence the strength of the association between early B-LRI and later psychological change.

A first pattern relates to initial distress and self-critical perfectionism. Zuroff et al. (2000) found that early B-LRI predicted greater improvement among clients who started treatment with high distress, while high levels of self-critical perfectionism lessened the link between B-LRI and outcome. Growth in patient-rated alliance partly explained this ($r = .46$, $p < .001$). In further research, Zuroff et al. (2010) again identified perfectionism as a key moderator: between-therapist B-LRI predicted quicker progress on the Composite Maladjustment Index ($F(1,497) = 4.73$, $p < .05$), and interactions with perfectionism predicted reductions in vulnerability ($F \approx 7.60$, $p < .01$). Zuroff et al. (2016) additionally showed that clients high in self-criticism displayed weaker links between early B-LRI and improvement (t values –3.20 to –4.26), whereas clients with lower perfectionism or higher need for connection showed stronger relational effects.

These findings suggest that the influence of the quality of the therapeutic relationship is diminished for clients whose internal frame of reference is dominated by self-critical or self-attacking tendencies during the early phase of therapy.

A second pattern involves interpersonal engagement at the start of therapy. In an IPT sample, Dolev and Zilcha-Mano (2019) identified a compensation effect: clients low in interpersonal involvement showed greater improvement when early B-LRI scores were high ($\Delta\beta = -4.02$, SE = 1.44, $p = .006$). This effect was not observed in the placebo condition, indicating that a higher B-LRI score may be especially important for clients who begin therapy with interpersonal constraints or relational withdrawal.

A third pattern involves early participation and relational reciprocity. Elkin et al. (2014) found that early behavioural engagement, measured by VTAS, predicted later B-LRI and reduced dropout ($\Delta R^2 = .06$, $p < .05$), indicating that early participation not only reflects clients' perceptions but can also enhance their subsequent relational experience. Murphy & Cramer (2014) reported that an interaction between client and therapist B-LRI predicted early distress ($\beta \approx -.23$, $p \approx .037$), emphasising that the client's perception of the three therapists' conditions alone does not fully capture the relational process; relational change develops through reciprocal perception and responsiveness.

Across these six studies, a consistent pattern emerges: the link between early B-LRI and subsequent outcomes is conditional rather than fixed. Factors such as initial distress, perfectionism, interpersonal involvement, and early engagement influence the strength and direction of the association. These findings align with Rogers's view that therapeutic change depends not only on the presence of the quality of the therapeutic relationship but also on the client's internal readiness, openness, and capacity to receive and use those attitudes.

The moderating effects emphasise that clients vary in how they respond to relational conditions, and that early perception of the three therapists' conditions interact dynamically with their internal frame of reference and interpersonal functioning.

2.6 Discussion

This systematic review shows that research using the B-LRI largely supports Rogers' (1957, 1959) proposal that the quality of the therapeutic relationship during the early phase of therapy can lead to constructive personality change. However, the temporal ordering hypothesis implied by the six necessary and sufficient conditions has seldom been tested comprehensively at a methodological level. This gap is significant because Rogers (1957, 1959) described all six conditions as collectively necessary and sufficient for meaningful personality change: assessing only some of them risks distorting the original hypothesis. Accordingly, this review evaluates not only whether B-LRI scores are associated with outcome, but which of the six conditions are being operationalised, how they are assessed, and to what degree of fidelity to Rogers' original model.

With respect to the six necessary and sufficient conditions, Conditions 1 and 2 are typically not measured directly in B-LRI research but are largely established by design. In these university-based research clinics and large-scale psychotherapy trials (e.g., the TDCRP), the participants completing the B-LRI were clients actively engaged in counselling or psychotherapy, thereby establishing psychological contact (Condition 1) and the presence of client incongruence or vulnerability (Condition 2) by design. As a result, empirical attention has focused primarily on the remaining conditions, particularly those relating to the quality of the therapeutic relationship as perceived by the client.

From the B-LRI findings, the most consistent evidence relates to Condition 6—the client's perception of the three therapists' conditions. Across various therapy modalities, including PCT, CBT, interpersonal psychotherapy, and even pharmacotherapy, early client-rated B-LRI scores indicate that the three therapists' conditions predict engagement and later improvement (e.g., Bayliss-Conway et al., 2021; Beckham, 1992; Blatt & Zuroff, 2005; Dolev & Zilcha-Mano, 2019; Elkin et al., 2014; Kolb et al., 1985; Murphy & Cramer, 2014; Zuroff et al., 2016). These findings reaffirm Rogers' insight that the client's perception of the three therapists' conditions is central to later improvement in optimal functioning across different therapeutic approaches. Without Condition 6, Conditions 3 to 5 are, by definition, inert; it is the client's lived experience of the quality of the therapeutic relationship that drives therapeutic progress and thus provides the clearest means of testing Rogers' hypothesis in relation to outcome. Among the three therapists' conditions, empathy and congruence (Conditions 3 and 5) receive relatively strong support: B-LRI congruence and clinician-rated genuineness predict outcomes, and therapist-level differences indicate that some practitioners consistently provide more congruent relationships (Elkin et al., 1999; Zuroff et al., 2010).

By contrast, Condition 4 raises particular challenges for empirical testing within the B-LRI literature because it seeks to operationalise a pervasive attitudinal stance rather than a discrete therapist behaviour or response. Barrett-Lennard's decision to divide UPR into two subscales—Level of Regard and Unconditionality—reflected an explicit attempt to manage this complexity. The separation was intended to distinguish between the client's sense of being positively valued and the extent to which that valuing remains non-contingent across different relational moments. This structural distinction was theoretically

motivated rather than arbitrary, acknowledging that unconditionality could not be adequately captured by a single factor.

However, this attempt to preserve conceptual breadth has proven difficult to sustain empirically. Factor-analytic studies have repeatedly reported low loadings for the Unconditionality subscale and substantial overlap with the Level of Regard (Blatt et al., 1996). As a result, all the related studies from the TDCRP dataset have retained Level of Regard while excluding unconditionality items altogether (Wampler & Power, 1982; Ganley, 1989; Blatt & Zuroff, 2005). The consequence of this practice is not merely technical. When unconditionality is omitted, Condition 4 is effectively reduced to a measure of warmth or general positive regard, rather than retained as a distinct attitudinal condition. Adaptations such as simplified subscale structures or alternative scoring methods may be defensible on psychometric grounds. However, they alter how the quality of the therapeutic relationship is operationalised and reduce fidelity to Rogers's six necessary and sufficient conditions as a unified hypothesis. Consequently, literature exhibits a persistent problem of construct validity. As Farber et al. (2018) noted, this has contributed to ongoing ambiguity in the literature regarding what is being measured under the label of positive regard, weakening claims that Rogers' six conditions have been fully represented. Variation in scoring practices across studies, however, continues to limit comparability and weakens claims that the full set of conditions has been examined.

Beyond these structural concerns, the manner in which the B-LRI has been used in empirical research raises further questions about its alignment with Rogers's theoretical model. More than 120 studies have applied the B-LRI across a wide range of designs, often analysing selected subscales and in different settings. More than 50 studies (e.g., Cramer, 1988; Cramer, 1996; Fretz, 1966; Bockmier-Sommers et al., 2017; Swan et al., 2020) employ the B-LRI in contexts

that do not explicitly assess Rogers's first condition of psychological contact, thereby weakening the conceptual link between the measure and the relational assumptions embedded within the six necessary and sufficient conditions for personality change.

Furthermore, numerous studies have focused on individual subscales for specific analytical purposes. For instance, Layton and Wykle (1990) focused exclusively on the empathy items to evaluate reliability, while Oh et al. (2012) examined only unconditional positive regard within a path-analytic model. The empathy subscale has been most frequently isolated, with over 50 studies assessing it independently, and it has demonstrated good reliability across both therapeutic (Watson et al., 2014; 2020) and medical settings (Moghaddasian et al., 2013; Chu & Tseng, 2013). Although this selective approach demonstrates the instrument's flexibility, analysing isolated subscales fragments the six necessary and sufficient conditions and diverges from the original intended use of the B-LRI. Rogers described the conditions as an interdependent relational configuration rather than as discrete or additive components. When empathy or unconditional positive regard is studied in isolation, the meaning of what is being tested changes. Thus, the core issue concerns how the quality of the therapeutic relationship is understood and operationalised, not the measure itself.

Historical debates reinforce this perspective and emphasise why producing a clear empirical test of Rogers's six necessary and sufficient conditions hypothesis has remained so elusive. Carkhuff (1969) and Egan (1975) stated that the facilitative conditions may be necessary but not sufficient for many clients (See Lockhart, 1984). In their view, the three therapists' conditions establish the emotional climate for exploration, but additional action-oriented or "additive" conditions are often required to facilitate bigger change. Mitchell et al. (1977), re-examining Truax's early work, argued that therapist behaviours such

as confrontation, self-disclosure and problem-solving may also contribute to client movement. Their critique suggested that therapeutic change may arise from a broader constellation of interpersonal processes than the three therapists' conditions alone. Their position implies that constructive personality change depends not only on the presence of the facilitative conditions but also on supplementary therapeutic interventions, thereby directly refuting Rogers's sufficiency claim.

Patterson (1974) aimed to reconcile these perspectives by differentiating between "responsive" and "initiative" therapist behaviours. He contended that more active interventions—such as immediacy, confrontation, or a well-timed challenge—should not be regarded as deviations from Rogers's hypothesis but as integrative behaviours emerging from the same relational foundation. Since no clear boundary separates responsive and initiative behaviours, the therapist's empathy, congruence, or acceptance may naturally develop into more active forms of engagement when the client's process requires it. Initiative interventions are, in fact, extensions of the facilitative conditions and therefore do not indicate that the conditions are inadequate. Their presence might instead explain the diversity of therapeutic expressions through which the conditions operate, rather than undermine the sufficiency of Rogers's hypothesis.

Other researchers focused on the timing and specificity of the necessary and sufficient conditions. Lockhart (1984) warned that averaging B-LRI scores across an entire therapy could obscure the moments when the three therapists' conditions exert their greatest influence. From a Rogerian perspective, therapeutic movement often unfolds at points of emotional risk or openness; therefore, a single global score may flatten out the very process it aims to capture. Gurman's (1973) "empathic specificity" hypothesis explains this further by proposing that empathy is not equally potent in all moments or for all

material but is most effective when it resonates with the client's core themes—the places of deepest incongruence. These critiques demonstrate that the client's perception of the three therapists' conditions is not a fixed quantity to be measured or averaged. Instead, they are dynamic relational processes that vary depending on the client, the specific moment, and the manner of the client's experience process. As a result, traditional research designs struggle to capture how the conditions function in therapy. Therefore, these debates highlight why Rogers's hypothesis has resisted decisive empirical confirmation and why contemporary research must consider when, how, and for whom the conditions are most transformative.

Client factors further shape this process. Greater initial depressive distress amplifies the positive effect of high early B-LRI, whereas self-critical perfectionism weakens it (Zuroff et al., 2000; Blatt & Zuroff, 2005). Clients who are low in interpersonal involvement benefit most when they perceive strong therapist empathy, regard and congruence. Some therapists consistently evoke higher B-LRI scores and achieve faster improvement (Zuroff et al., 2010), showing that outcomes depend on both client readiness and therapist responsiveness. The relationship between B-LRI and the therapeutic alliance underscores this point: B-LRI ratings collected early often precedes alliance growth and sometimes predict outcomes beyond what alliance measures explain. The client's perception of empathy, positive regard and congruence captures a distinctive experiential dimension that initiates engagement; the alliance may be one pathway through which these perceived conditions exert influence, but it is not interchangeable with them.

For Rogers's hypothesis to be convincingly supported, such client–therapist interactions must be modelled as part of the same causal pathway. In practice, this means that the client's initial level of incongruence, their

perception of the three therapists' conditions, their moment-to-moment experiencing, and their later movement toward congruence need to be represented within one integrated temporal model rather than examined as separate associations. The variables must be positioned in the sequence Rogers described: the client enters therapy in a state of incongruence; they perceive the three therapists' conditions; this perception facilitates deeper experiencing; and this deeper experiencing leads to greater congruence or authenticity. Statistically, this requires longitudinal modelling that captures directionality, timing, and mediating processes, such as cross-lagged panel models, longitudinal SEM or mediation models with repeated measures. Instead of correlating conditions with outcomes at a single point, researchers must show that the conditions exert their influence *through* the client's internal process and that these effects unfold over time in the order Rogers proposed.

Methodological limitations qualify these conclusions and, crucially, limit the field's ability to test Rogers' personality theory (1959) as he intended. When the conditions are measured inconsistently, assessed only once, or examined within designs centred on symptom reduction, the theory becomes fragmented. These methodological choices shape what can be concluded and often narrow the focus to therapist behaviours rather than to the client's lived experience of the process. Among the work reviewed in Table 2.3, only Murphy and Cramer (2014), Bell et al. (2016), and Bayliss-Conway et al. (2021) match that level of Rogers' fidelity of testing the six conditions into an integrated model. Compared with the wider literature—where Conditions 1 and 2 are usually assumed, and UPR is often modified—these three studies stand out as the most faithful operationalisations of Rogers' hypothesis. They preserve the client's perception, treat the conditions as a single relational climate and follow change across sessions. They show what becomes possible when the theory is modelled as

Rogers intended, but they also highlight how far the wider field has moved away from that approach. Therefore, these issues clarify why so few studies have been able to test the hypothesis as a unified relational model.

A further limitation arises from how the quality of the therapeutic relationship is captured through the client report. Client ratings rely on self-report and are vulnerable to social desirability and halo effects (Cramer, 2009; Paulhus, 2002). Clients may not clearly distinguish empathy, congruence and positive regard, often experiencing them as an overall relational climate rather than as separate attitudes (Farber et al., 2019). This aligns with Rogers' view that the six conditions work together in shaping the therapeutic relationship, yet it also raises questions about whether B-LRI subscales should be analysed separately or whether a global score better reflects this unity (Gurman, 1977; Murphy & Cramer, 2014). These measurement issues interact with broader design choices.

Treating the B-LRI subscales as independent predictors implicitly assumes that these therapist attitudes exert separable effects. Analysing subscales in isolation may therefore introduce artificial distinctions that are not phenomenologically grounded and risk fragmenting a construct that Rogers conceptualised as inherently holistic. Conversely, reliance on a global B-LRI score reflects the integrative nature of the six conditions but limits the capacity to examine the relative contribution of individual therapist attitudes. This tension highlights a broader methodological trade-off: studies prioritising subscale analyses gain analytic specificity at the expense of theoretical fidelity, while those using total scores align more closely with the quality of the therapeutic relationship but sacrifice granularity. Consequently, findings derived from subscale-based analyses should be interpreted with caution when used to

evaluate the six necessary and sufficient conditions as a claim of testing Rogers' hypothesis.

A further limitation concerns the manner in which constructive personality change has been operationalised in the empirical literature. By focusing almost exclusively on depressed client populations (k= 15 from Table 2.3) and defining therapeutic success primarily through symptom reduction, most commonly via the BDI or HDRS—the literature implicitly reframes Rogers' hypothesis within a medicalised outcome model. This reframing shifts the meaning of *constructive personality change* away from Rogers' intended developmental outcomes, such as increased congruence, authenticity, and reduced alienation, and toward symptom alleviation, well-being and optimal functioning. As a result, the outcome variables used in the TDCRP research studies do not fully correspond to the theoretical claim being evaluated. Therefore, the limited number of studies assessing broader developmental outcomes restricts the conclusions that can be drawn about the six conditions as a general theory of personality change.

Finally, the evidence base remains culturally and contextually limited. Although Rogers' six necessary and sufficient conditions are proposed as a broadly applicable framework for psychotherapy, the empirical research testing these claims is predominantly from Western, English-speaking university counselling centres. As a result, the perceived generalisability of the six conditions is mainly based on samples from individualist cultures that emphasise personal autonomy, self-expression, and intrapersonal awareness. The lack of studies from non-Western or more collectivist contexts further narrow the scope of current conclusions. This suggests that some of the observed effects may be culturally specific assumptions about selfhood, emotional expression, and

relational boundaries rooted in Western individualist societies, rather than universal features of the six conditions themselves.

2.7 Conclusion

This chapter systematically reviews the literature on the B-LRI to evaluate whether Rogers's six necessary and sufficient conditions for constructive personality change have been thoroughly tested. Overall, the reviewed studies show that the B-LRI is widely used to assess the quality of the therapeutic relationship and has consistently been linked to process variables. Across various designs and settings, higher early B-LRI scores are associated with greater engagement (Kolb et al., 1985), continuation in therapy (Beckham, 1992; Elkin et al., 2014), and later indicators of congruence (Elkin et al., 1999). This pattern aligns with Rogers's (1959) idea that when clients perceive conditions of empathy, congruence, and unconditional acceptance, defensiveness diminishes and engagement with the therapeutic process becomes possible.

At the same time, the review indicates that the six necessary and sufficient conditions have rarely been examined with explicit attention to temporal ordering across relational, process, and outcome variables. Much of the existing research treats the perception of the quality of the therapeutic relationship as static predictors and focuses on proximal indicators such as engagement or retention. As a result, it provides limited insight into how early relational perceptions are linked to later indices of authenticity. More recent work has begun to suggest that clients' perception of the three therapist conditions may be temporally associated with authenticity (e.g. Bayliss-Conway et al., 2021), yet the process through which this association unfolds remains insufficiently specified. Consequently, although early perceptions of the therapists' conditions appear important, the literature offers limited evidence

regarding how these perceptions are received and organised by the client across time.

This highlights a critical gap. Rogers's theory does not suggest that the three therapists' conditions directly lead to developmental outcomes such as authenticity. Instead, these Conditions 3 to 5 are first perceived by the client and then engaged with within an experiential process that develops over time. Clarifying how authenticity is temporally connected to early relational perception, and how specific ways of experiencing might organise this relationship, is therefore essential to better understand the process assumptions embedded within Rogers's six necessary and sufficient conditions. The following chapter first considers authenticity as a concept that is temporally distant, before exploring experiencing as the process through which perceived therapist conditions may relate to later progress towards greater congruence.

Chapter 3: *Experiencing, Authenticity, and the Process of Constructive Personality Change*

3.1 Introduction

Psychotherapy research continues to return to a central question: how and why do clients develop within therapy? Across theoretical orientations, there is strong evidence that the quality of the therapeutic relationship is one of the most reliable predictors of outcome. Yet relational findings are often presented descriptively, without a coherent process theory that explains how clients receive the quality of the therapeutic relationship and translate it into directional psychological development over time. This tension is particularly evident in person-centred therapy (PCT), where Rogers six necessary and sufficient conditions were never intended as techniques, but as part of a broader theoretical account of personality development.

Central to this account is the actualising tendency (AT), which Rogers conceptualised as an inbuilt, directional capacity present in all living organisms. The AT is not an end state, but an ongoing process through which individuals strive to preserve, develop, and enhance their existence. Within therapy, the three therapists' conditions, established through the six necessary and sufficient conditions, do not create the AT but rather facilitate its expression. When clients perceive empathy, unconditionality, and congruence, the probability of reconnecting with their organismic valuing process (OVP) increases, supporting openness to experience and movement toward greater authenticity and integration. As Kriz (2007) clarifies, the AT is best understood as a self-organising process through which persons adapt, reorganise, and develop in response to

their relational environment. Development occurs when the quality of the therapeutic relationship allows this self-organising process to unfold within the client. Rogers's six conditions, therefore, function as a relational mechanism rather than a set of helpful attitudes.

Conditions 3 to 5 establish a psychological climate that invites engagement, but clients may experience them differently. Rogers's (1957, 1959) hypothesis presupposes an ongoing client process through which the three therapists' conditions are gradually received, explored, and assimilated within experiencing, alongside an emergent developmental direction through which constructive personality movement becomes increasingly recognisable over time. As these conditions are experienced as trustworthy and non-evaluative, reliance on external conditions of worth may diminish, allowing greater openness to lived experience and closer alignment between experience and self-concept. Therefore, the client's perception of the three therapists' conditions alone cannot fully account for how development unfolds. If constructive personality functioning is understood as both relational and directional, it must involve a process in which the client's perception of the facilitative relationship gives rise to movement in the predicted direction, rather than an immediate response to the therapist's input.

Empirical examination of this process requires translating a process-oriented theory into observable indicators without undermining its conceptual integrity. As illustrated in Figure 1.1, Rogers's framework spans multiple conceptual domains, making it inappropriate for any single empirical study to operationalise the theory in its entirety without distortion. Rogers did not specify time lags, measurement instruments, or statistical criteria for identifying constructive personality development, making some degree of operational translation unavoidable. What is required instead is an approach that targets a

theoretically central pathway—one that preserves the relational mechanism of development, attends to how clients receive and engage with the therapist's conditions, and indexes directional functioning over time.

Three dimensions are theoretically central to testing Rogers' six necessary and sufficient conditions. First, whether the client's perception of the three facilitative therapists' conditions is present. Second, the client's manner of engaging with inner experience reflects how the therapist's conditions are perceived and assimilated within therapy. This dimension indexes experiential engagement as relational facilitation is encountered. Third, movement toward greater authenticity indexes developmental direction, as reflected in reduced alienation, decreased acceptance of external influence, increased openness to experience, and greater alignment between lived experience and self-concept.

Accordingly, this chapter develops the conceptual and empirical foundations of experiencing and authenticity as indicators of constructive developmental direction within PCT. It examines how these constructs have been theorised and studied in the literature and clarifies their role within the broader relational framework proposed by Rogers. By doing so, the chapter establishes the basis for examining whether variations in how clients engage with their experience mediate the relationship between early perceptions of the three therapist's conditions and later movement toward authenticity. This framework directly informs the longitudinal model tested in the present study.

3.2 Relational Foundations and Outcome

Empirical research across therapeutic modalities supports the centrality of relational variables. The APA Task Force on Evidence-Based Relationships demonstrated that empathy, congruence, and unconditional positive regard each make independent contributions to therapeutic outcome (Norcross & Lambert,

2011). These findings are pan-theoretical, indicating that relational factors constitute a common foundation for therapeutic change rather than a modality-specific assumption. Within PCT, they align closely with Rogers' claim that the three therapists' conditions are sufficient insofar as they are perceived by the client within a genuine relational encounter.

The significance of the therapeutic relationship lies not primarily in symptom reduction. Rogers did not conceptualise psychological distress as a set of symptoms to be eliminated, but as incongruence—a misalignment between the self-concept and organismic experience. Symptom change is therefore secondary to a more fundamental shift in how the person relates to their own experience. Psychological health is not defined by the absence of distress, but by the degree to which the person can rely on their own OVP. When the therapeutic relationship provides conditions under which experience can be symbolised without threat, the client's AT is able to operate more freely. Through this freer operation of the AT, movement toward congruence becomes possible, and optimal functioning can emerge as a developmental outcome rather than a presupposed state. Ford (1991) proposed that both psychopathology and well-being depend on the degree of alignment between experience, awareness, and self-concept, a position supported by Wilkins (2005), who reported that greater congruence is associated with higher psychological well-being, whereas lower congruence is associated with distress. Distress is thus understood not as pathology, but as an indicator that experience is being denied, distorted, or organised around external conditions of worth.

Rogers' (1957, 1959) hypothesis of the six necessary and sufficient conditions reflects a distinct epistemological position that places the client's subjective experience at the centre of the therapeutic process. Murphy and Joseph (2016) emphasised that psychological suffering is best understood from

the client's frame of reference; accordingly, the client is regarded as the primary authority on their own experience, while the therapist's role is secondary. The therapeutic relationship is therefore facilitative rather than corrective: it does not impose change but provides the relational conditions under which the client's AT toward growth and integration can be realised.

Research examining the quality of the therapeutic relationship indicates that meaningful change can occur through the therapeutic relationship alone. Freire et al. (2015) found that PCT and low-intensity cognitive–behavioural therapy were similarly effective for clients experiencing depression. Dolvey and Zilcha-Mano (2017) further reported that clients' early perceptions of the three therapists' conditions were associated with better early interpersonal outcomes. Beyond symptom-focused outcomes, the client's perception of the three therapists' conditions has also been linked to post-traumatic growth, including enhanced meaning-making, increased personal strength, and greater relational depth (Payne et al., 2007; Hearn et al., 2021). Such outcomes are consistent with movement toward more authentic and congruent ways of being, rather than symptom reduction alone.

A recurring concern within the literature, however, is the reliance on medicalised outcome measures that prioritise diagnostic change over subjective personality development. Kolden et al. (2011) argued that symptom-based measures are poorly aligned with PCT's emphasis on growth and optimal functioning. Schmid (2005) similarly described alienation as a "cry for help," framing incongruence as a disturbance in self-alignment rather than a pathological deficit. Conceptualising therapeutic change primarily in diagnostic terms risks obscuring the client's lived experience and reinforcing external standards of evaluation.

Therefore, Rogers's hypothesis of constructive personality change requires outcome indicators that capture movement rather than static end states (Ellis, 2013). Incongruence arises when experience is organised around introjected values and conditions of worth, leading the person to rely on external evaluation rather than organismic valuing (Rogers, 1959). Psychological change involves a reorganisation of the person's sources of valuation, marked by reduced reliance on external standards and increasing trust in OVP. Congruence is thus a developmental outcome that becomes possible when the quality of the therapeutic relationship is perceived and taken up by the client. As reliance on introjected values diminishes, harmony between experience, awareness, and self-concept increases. This temporal sequencing is central to Rogers's six necessary and sufficient conditions hypothesis and guides the conceptualisation of the outcome in the present study.

Because optimal functioning is a phenomenological process and cannot be directly observed, empirical research must rely on indicators that capture the client's shifting sources of valuation. Therapeutic change is therefore reflected in reduced acceptance of external influence and alienation, alongside a renewed capacity for internal valuation, signalling movement toward congruence and the freer operation of the AT (Bohart, 2013; Finke, 2002). The Authenticity Scale (AS; Wood et al., 2008) is theoretically aligned with this model of change. Rooted in Rogers's account of alienation, the AS operationalises authenticity through dimensions that reflect conditions of worth and their experiential consequences. Rather than treating authenticity as a stable trait, the scale captures the degree to which individuals live in accordance with their felt experience or remain organised around external standards of evaluation. As such, the AS provides a coherent proxy for outcome-level change consistent with Rogers's model of optimal functioning.

3.2.1 Authenticity Scale

The AS (Wood et al., 2008) comprises 12 items rated on a 7-point Likert scale, ranging from 1 (does not describe me at all) to 7 (describes me very well). Table 3.1 presents the items from the Authenticity Scale, organised into three theoretically grounded subscales: Authentic Living, Accepting External Influence, and Self-Alienation. Each subscale contains four items. *Authentic Living* reflects the extent to which an individual behaves in ways that are consistent with their core beliefs, values, and feelings. High scores on this subscale suggest a more congruent and integrated sense of self*. Accepting External Influence* captures the tendency to conform to others' expectations and to be overly shaped by social or relational pressures. Elevated scores on this dimension indicate a diminished sense of autonomy and a weaker internal frame of reference, which may interfere with the individual's AT. *Self-Alienation* measures the degree to which individuals feel disconnected from their inner experience, such as not knowing what they feel or feeling out of touch with the 'real me'. High scores on this dimension indicate internal fragmentation or psychological distress, echoing Rogers's concept of incongruence between self-concept and experience.

Table 3.1. Items from the Authenticity Scale Grouped by Subscale

Subscale	Item No.	Item Statement
Authentic Living	1	"I think it is better to be yourself, than to be popular."
	8	"I always stand by what I believe in."
	9	"I am true to myself in most situations."
	11	"I live in accordance with my values and beliefs."
Accepting External Influence	3	"I am strongly influenced by the opinions of others."
	4	"I usually do what other people tell me to do."
	5	"I always feel I need to do what others expect me to do."
	6	"Other people influence me greatly."
Self-Alienation	2	"I don't know how I really feel inside."
	7	"I feel as if I don't know myself very well."
	10	"I feel out of touch with the 'real me'."
	12	"I feel alienated from myself."

Note. Adapted from Wood et al. (2008)

The total score on the AS reflects the extent to which an individual's sense of self is organised around internally experienced values, feelings, and

meanings rather than external expectations. Items assessing Self-Alienation and Accepting External Influence are reverse scored so that higher total scores consistently indicate greater authenticity. Higher scores therefore reflect stronger congruence between lived experience, self-concept, and behaviour, characterised by openness to experience and reliance on internal evaluation. Lower scores indicate stronger external self-evaluation and greater distance from one's own feelings, reflecting lower overall congruence.

Wood et al. (2008) demonstrated that the 12-item three-factor Authenticity Scale showed good internal consistency (α = .70–.80) and strong test–retest reliability (r = .78–.91). Across samples, higher Authentic Living and lower Self-Alienation or AEI were associated with greater self-esteem, life satisfaction, and psychological well-being, even after controlling for the Big Five personality traits. These findings provide empirical support for Rogers' proposition that movement away from alienation and conditions of worth, and toward congruence and authentic living, is associated with psychological growth.

The AS does not conceptualise authenticity as a fixed personality trait, but as a mode of self-organisation that is sensitive to interpersonal and contextual conditions. Levels of Authentic Living, Accepting External Influence, and Self-Alienation reflect how individuals currently relate to their experience and sources of evaluation. This makes the AS particularly suited to psychotherapy research, where directional development may emerge through shifts in relational experience over time. Authenticity can therefore be understood as an experiential indicator that may fluctuate in relation to the quality of the therapeutic relationship. This distinction has direct implications for how the factor structures of the AS and Barrett-Lennard Relationship Inventory (B-LRI) are interpreted.

The Congruence subscale of the B-LRI captures whether the therapist is perceived as genuine and transparent, whereas the Authentic Living subscale of the AS reflects the client's sense of being true to self. When a therapist consistently embodies congruence, the relational climate may support the client's AT, increasing the likelihood of directional movement toward authenticity. Similarly, the Unconditionality subscale of the B-LRI reflects the therapist's non-evaluative stance, whereas Accepting External Influence reflects the extent to which the client remains organised around external standards of worth. When unconditional positive regard is perceived, reliance on external evaluation may diminish. Conversely, persistently low authenticity scores may indicate that the therapist's congruence and unconditionality have not been sufficiently perceived or integrated by the client, resulting in limited movement away from alienation and weaker constructive direction. Authenticity, therefore, serves as an appropriate directional indicator for examining Rogers' hypothesis that clients' perception of the three therapists' conditions facilitates growth in a constructive direction.

However, several studies have questioned the stability and distinctiveness of AEI (Knoll et al., 2015; Lenton et al., 2016; Lutz et al., 2021; Moerken and Cooper, 2023). Lenton et al. (2016) argued that AEI may represent a context-dependent manifestation of authenticity rather than a core experiential dimension, suggesting that a two-factor model may better reflect experiential processes. Additionally, the Authentic Living subscale has shown weaker loadings in some studies (Cartwright et al., 2023; Toper et al., 2020). These findings suggest that the proposed sub-dimensions may not represent stable constructs across samples.

3.2.2 Authenticity, Process and Directionality

Empirical research has not reached consensus regarding the temporal role of authenticity within processes of psychological development. Across the literature, authenticity has been conceptualised variously as a predictor, mediator, and later indicator, depending on context and study design. This variability reflects an unresolved issue concerning directionality and the internal processes through which authenticity may emerge over time.

The AS has frequently been used to trace pathways linking authenticity to well-being. Proctor et al. (2015) found that Rogers concept of the fully functioning person was associated with greater life satisfaction and more positive emotional experience. Using a cross-lagged panel design, Boyraz et al. (2014) reported a unidirectional pathway in which earlier authenticity predicted later increases in life satisfaction, which in turn reduced psychological distress. This temporal ordering is broadly consistent with Rogers' proposition that congruence may precede growth-related functioning.

Longitudinal studies conducted outside therapeutic contexts largely support this pattern. In student and occupational samples, authenticity has been shown to predict later well-being, meaning in life, and psychological adjustment (e.g., Proctor et al., 2015; Lutz et al., 2021), suggesting that authenticity often functions as a precursor to positive functioning. However, other studies indicate more complex or reciprocal patterns. Knoll et al. (2015) reported bidirectional associations between authenticity and well-being in occupational settings, while Chen and Murphy (2019) observed cultural variation in these processes, with mindfulness predicting authenticity among Chinese but not White British students. Zheng et al. (2019) similarly identified mindfulness as a variable linking authenticity and well-being. Together, these findings indicate that authenticity

does not occupy a fixed position within a universal developmental sequence but may emerge through context-dependent processes.

Research conducted closer to therapeutic settings further underscores the role of relational and process variables. Kim et al. (2020) found that relational depth was associated with higher authenticity and unconditional positive self-regard, suggesting that relational engagement may precede later shifts in authenticity. Longitudinal findings from the Human Flourishing Project (HFP) similarly indicate that clients who perceive stronger therapist conditions early in therapy show higher authenticity at later sessions (Bayliss-Conway et al., 2021), and that authenticity increases across therapy among clients presenting with suicidal ideation (Sohal & Murphy, 2022). While these studies establish temporal associations, they do not specify how therapist conditions may be translated into internal personality development.

In summary, two key limitations remain. First, directionality is unclear: authenticity appears in the literature as a precursor to well-being, a later indicator associated with relational conditions, or part of a reciprocal process. Second, few studies explicitly model the internal process through which relational conditions are associated with later authenticity. Authenticity is often treated as if it shifts directly in response to the therapeutic relationship, with limited attention to the experiential mechanisms that may account for this association.

This gap is particularly salient within PCT. Rogers did not conceptualise personality development as an immediate outcome of therapist attitudes, but as a gradual internal process unfolding as clients become more open to experience and better able to symbolise it accurately in awareness. This developmental account is reflected in Rogers's stages of process (Rogers, 1961), which describe qualitative shifts in how clients relate to their inner experience over time.

Addressing this gap requires identifying a process variable that captures how clients receive and engage with the therapist's conditions, rather than assuming a direct relationship between relational perception and later functioning. Stephen (2023) described a pathway toward congruent functioning characterised by increasing self-awareness, self-trust, and self-acceptance, culminating in greater openness to self and others. This pathway suggests that relational conditions may operate indirectly, supporting internal processes through which clients move toward greater congruence rather than through technique or instruction.

When considered alongside the Experiencing Scale (EXP; Klein et al., 1986), a clear conceptual convergence emerges. Both frameworks conceptualise therapeutic development as a progressive deepening of engagement with present-moment experience and increasing emotional integration. The EXP therefore, offers a process-oriented means of examining how clients' internal engagement may develop in response to their perception of the three therapists' conditions, shifting the focus from outcomes alone to the mechanisms through which the six conditions may foster meaningful and sustained personality development.

3.3. Experiencing as a Relational Process

A significant methodological shift in psychotherapy research occurred in the 1950s when Rogers began recording therapy sessions. This development enabled researchers to move beyond outcome-focused evaluation and examine the therapeutic process itself, namely what occurs within the encounter between client and therapist. Rather than asking only whether therapy was effective, researchers were increasingly able to investigate how therapeutic development unfolded moment by moment within the relational context. This focus on

encounter also resonates with broader dialogical understandings of human development.

Using audio recordings, Rogers and his colleagues were able to examine how clients engage with and process their inner experience within the therapeutic relationship, providing an empirical basis for understanding how relational conditions may support movement in a constructive direction. Central to Rogers' theory was the view that the client actively participates in therapy. When clients perceive the therapist's conditions as present, they may become better able to attend inwardly, access felt experience, symbolise emotions more accurately, and integrate previously unacknowledged aspects of the self. Rogers later described this internal process as experiencing, defining it as the client's capacity to explore, reflect upon, and interpret felt experience in the present moment (Rogers, 1950).

Within therapeutic dialogue, empathic understanding allows clients to feel deeply received without judgement, creating relational safety for the expression of implicit or previously denied experience. This safety may reduce the need for defensive distortion associated with conditions of worth and support clients in turning toward their felt sense. Unconditional positive regard further facilitates this process by reducing reliance on external evaluation, enabling clients to experience acceptance without needing to meet imposed expectations. Therapist congruence models openness and authenticity within the relationship, inviting a similar stance in the client. Together, these three relational conditions do not direct development through technique; rather, they create a climate in which clients may symbolise and integrate lived experience.

While Rogers (1961) articulated stages of process associated with therapeutic development, less attention was initially given to how clients differed in their capacity to engage with these conditions at the level of lived

experience. This question was taken up by Gendlin and his colleagues during their work on the Wisconsin Schizophrenia Project. Working closely with Rogers at the University of Chicago, Gendlin sought to measure the "*manne*r" of experiencing reflected in the client's emotional engagement during sessions. This shift placed the client's experiential process at the centre of therapeutic development.

Kirtner and Cartwright (1958) introduced a set of client classifications, ranging from V to Z, based on behaviours observed during the initial therapeutic interview. These classifications captured systematic differences in openness and emotional self-exploration. Clients classified in group V demonstrated sustained internal focus and active engagement with experience and were more likely to show favourable therapeutic functioning. By contrast, clients in group Z tended to externalise, intellectualise, or avoid engagement with inner experience and were more likely to show limited progress. Importantly, therapeutic movement was associated not with the content of what clients discussed, but with how they related to their immediate felt experience—allowing vague or implicit feelings to emerge, be explored, and gradually take symbolic form.

These findings indicated that engagement with experience functions as a core process marker of therapeutic effectiveness. Clients with poorer outcomes often participated in dialogue without turning inward, relying instead on explanation, narrative, or external reference points. Experiencing, therefore captures the degree to which clients can attend to, symbolise, and integrate felt experience within the therapeutic encounter. This supports Rogers' view that the therapist's role is not to direct development, but to create relational conditions that allow the client's own experiential process to unfold. Constructive movement may occur when dialogue enables implicit meanings to emerge and be carried forward rather than remaining unarticulated or distorted.

Table 3.2 illustrates these classifications as progressively deeper modes of engaging with inner experience. The sequence moves from automatic physiological responding toward increasingly articulated and symbolised experience, capturing a developmental continuum that may fluctuate within and across sessions (see Margaret Warner, 2005).

Table 3.2: Client Classifications and Levels of Experiencing

Classification	Description
Physiological Processes	Automatic bodily responses such as changes in blood pressure, heartbeat, or respiration.
Physiological Body Sensing	Awareness of bodily sensations, such as muscle tension or pain, without broader emotional or contextual awareness.
Vague Sensing of a Situation	Unclear or image-based awareness of a life situation; includes bodily felt senses, gestures, or fleeting impressions.
Partially Articulated Version of a Situation	Tentative verbal formulations like "Something about X is getting to me" or "I have a vague feeling of Y."
Articulated Version of a Situation	Clear emotional awareness linked to context, such as "I feel X about Y because of Z." These are recognisable, structured expressions of inner experience.

Note: Adapted from Warner (2005, p. 100)

This method of client classification contributed directly to the development of the Experiencing Scale (EXP; Klein et al., 1969), which provides a systematic means of observing how clients engage with and process their inner experience during therapy, allowing for the examination of individual differences in experiential engagement as they evolve over time.

3.3.1 Experiencing Scale

The Experiencing Scale (EXP; Klein et al., 1969) is an observer-rated scale applied to brief segments of client speech drawn from audio-recorded therapy sessions. Rather than assessing what clients talk about, EXP captures how they attend to, symbolise, and relate to their felt experience as it is expressed in the moment. EXP differentiates clients' in-session engagement with experience across seven ordered levels, corresponding directly to Rogers' seven stages of therapeutic process. Each EXP level translates Rogers' phenomenological descriptions of process into observable features of client speech, allowing the seven stages proposed by Rogers (1961) to be examined empirically. At the lower levels (Stages 1–2), clients speak primarily in narrative form, recounting events with little or no personal reference. As clients move into the intermediate levels (Stages 3–4), personal referents begin to appear alongside tentative comments about reactions or feelings. However, these reflections remain closely tied to external events and are not yet used to understand the self. Speech at this level often conveys vague sensing, hesitation, and imprecise language, particularly at Stage 4, indicating emerging contact with experience without full symbolisation. At higher levels (Stages 5–6), the focus shifts decisively toward the self, as clients describe feelings, self-perceptions, and meanings with increasing clarity, using experience as a basis for self-exploration and understanding. At the highest level (Stage 7), clients move fluidly among feelings and meanings without relying on narrative structure, demonstrating an internally organised and flexible relationship to experience.

The EXP employs a structured scoring system designed to capture both the typical level of experiencing (mode) and moments of heightened engagement (peak). Importantly, EXP ratings are based on the form of expression rather than inferred insight or outcome, with each scoring unit consisting of a

spoken segment that may be summarised at the segment, session, or across-sessions level, depending on analytic aims. When EXP is linked to outcome variables, broader summary units tend to show stronger associations with outcome measures (e.g., Goldman et al., 2005; Pos et al., 2009), whereas studies examining immediate process effects often rely on shorter segments.

Table 3.3 Comparison of the Key Features of Rogers' Seven Stages of Process and the Experiencing Scale Stages

Stage (1–7)	EXP LEVEL	Rogers' Process Stage
1	Expression is impersonal and detached	The client is confused and unable to express feelings.
2	The speaker is the central character in the narrative, but still describes events only externally.	Client begins to express feelings but remains guarded.
3	Speaker begins to describe private reactions or awareness connected to events; some acknowledgement of inner experience.	Client starts to explore feelings and experiences more openly.
4	Feelings and inner perspective become the main subject	Client begins to accept feelings and experiences.
5	Purposeful exploration of inner experience	Client starts to integrate feelings into the self-concept.
6	Newly recognised feelings and experiences are synthesised	Client experiences self-acceptance and congruence.
7	Speaker moves freely among inner references, applying insights broadly; a sense of growth and ongoing exploration is evident.	Client becomes fully functioning.

Note: Refer to Appendix 7, Adapted from Rogers (1961) seven-stage process

Table 3.3 illustrates how Rogers' seven stages of process and the seven levels in the EXP describe the same underlying developmental movement using different registers. Both conceptualise therapeutic change in seven stages as a gradual shift from externally focused, emotionally distant communication toward increasingly immediate and integrated engagement with inner experience.

Change is thus located within the client's evolving manner of relating to experience. Consequently, the EXP provides a theoretically grounded method for observing the internal processes through which clients' perception of the three therapists' conditions exert their influence, allowing direct examination of Rogers' original process-level hypothesis. The next section reviews empirical evidence on client experiencing as a process variable and its relevance to the six conditions for constructive personality change.

3.3.2 Experiencing as a Relational Process and Outcome Indicator

Research across therapeutic traditions consistently indicates that the manner in which clients engage with their experience is closely shaped by the quality of the therapeutic relationship. Early process research suggested a close association between relational and experiential variables, yet left their temporal ordering unresolved. For example, Van der Veen (1970) observed that clients who reached higher levels of experiencing later in therapy also tended to perceive stronger therapist conditions, indicating a reciprocal association between relational perception and experiential depth. However, the direction of this relationship could not be established, leaving open the question of whether deeper experiencing leads clients to perceive the relationship more positively, or whether the therapist's conditions facilitate the deepening of experiencing.

Subsequent process research increasingly supports the view that clients' engagement with experience does not occur independently of the therapeutic relationship. Stiles et al. (1979) found that higher levels of experiencing were associated with greater personal disclosure, suggesting that emotional exploration intensifies when the relational context feels sufficiently safe. More direct evidence for therapist-initiated influence was provided by Kurtz and

Grummon (1972), who, using an early version of the Experiencing Scale, reported that therapist-offered empathy—assessed from session recordings—was the only relational factor associated with deeper self-exploration, while client-perceived empathy was the strongest predictor of later experiential engagement. Related findings by Watson and Bedard (2006) and Watson et al. (2011) further demonstrated that empathic responsiveness, reflective listening, and space for inward attention supported deeper levels of experiencing, whereas more directive or controlling interventions constrained emotional processing. Taken together, these studies suggest that the three therapist conditions, particularly empathy, play a key role in *initiating* experiential engagement, even as relational and experiential processes may become increasingly reciprocal over the course of therapy.

Within Rogers' theoretical framework, however, experiencing does not constitute a competing pathway to change, nor a process to be intensified through therapist activity. Rogers (1957, 1959) conceptualised Conditions 3 to 5 as a *facilitative climate* through which the client's AT can reorganise experience organically. From this perspective, experiencing reflects the form through which the OVP becomes accessible to awareness once sufficient relational conditions are perceived. While the therapist offers the conditions, the client's manner of experiencing shapes how these conditions are received and internalised over time, allowing for a bidirectional dynamic without undermining the primacy or sufficiency of the therapist's conditions.

This interpretation is reinforced by cautions against hastening clients through stages of change (Merry, 2014) and by concerns that later process-oriented emphases risk displacing Rogers' original focus on the AT (Brodley, 2011). Whereas Gendlin (1962) foregrounded trust in the experiencing process itself, Rogers placed primary emphasis on trust in the organism's inherent

tendency toward growth, given the perception of the therapist's conditions. From this standpoint, experiencing renders therapeutic change *visible* within sessions, but does not initiate it.

Within experiential and emotion-focused traditions, experiencing has frequently been examined in relation to the Working Alliance Inventory (WAI; Bordin, 1979), with studies consistently reporting positive associations between alliance quality and clients' level of experiential engagement (Goldman et al., 2005; Pos et al., 2003; Pos et al., 2009; Watson, 2006; Watson et al., 2011). For example, Goldman et al. (2005) showed that changes in clients' experiencing across therapy were associated with both early peak experiencing and early alliance in predicting reductions in depressive symptoms and increases in self-esteem, even when alliance alone was controlled. Using path analysis, Pos et al. (2009) reported evidence consistent with a unidirectional temporal association, whereby earlier alliance preceded later experiencing. These findings indicate that relational factors are temporally linked to clients' capacity for experiential engagement. However, within these traditions, the relational context is primarily operationalised through the WAI, which emphasises collaboration, agreement on tasks, and goals, rather than Rogers' therapist conditions as perceived by the client.

Despite this body of work, relatively few studies have examined how *client-perceived therapist conditions* and *client experiencing* mutually influence one another over time within a person-centred framework, or how variations in this temporal relationship relate to later personality outcomes. Building on the gap identified in Chapter 2, the temporal and potentially bidirectional relationship between client-perceived therapist conditions—measured by the B-LRI—and the client's level of experiencing has yet to be systematically examined using longitudinal designs capable of testing Rogers' proposed sequence.

To situate the role of experiencing within the relational framework outlined above, it is necessary to consider how the EXP has been used across therapeutic traditions and clinical contexts, and the forms of change with which it has most consistently been associated. Alongside its relational grounding, a substantial body of research has employed the EXP to examine in-session client process, most commonly among individuals presenting with depression, across a range of therapeutic modalities. These include Cognitive Behavioural Therapy (CBT; e.g., Castonguay et al., 1996; Pinheiro et al., 2020; Rudkin et al., 2007), Psychodynamic Therapy (e.g., Drapeau et al., 2018; Fisher et al., 2020), Emotion-Focused and experiential therapies (e.g., Singh et al., 2020; Watson & Bedard, 2006; Watson et al., 2011), Brief Relational Therapy (Nacheman, 2020), and Client-Centred Therapy (CCT; e.g., Pos & Greenberg, 2009; Toukmanian et al., 2010). Within this literature, depression has been the primary clinical context in which the EXP has demonstrated reliable associations with therapeutic outcome. Higher levels of emotional experiencing have generally been linked to more favourable outcomes, including symptom reduction and improvements in relational functioning.

Experiencing has also been shown to correlate with constructs such as self-esteem and the working alliance, as assessed by instruments including the Rosenberg Self-Esteem Inventory and the Working Alliance Inventory. These findings have contributed to the widespread characterisation of the EXP as a robust indicator of in-session therapeutic process, capable of capturing moment-to-moment emotional engagement that is not accessible through pre- or post-treatment outcome measures. Meta-analytic evidence further supports this view, with Pascual-Leone and Yeryomenko (2017) reporting a small-to-medium association between experiencing and outcome across a large clinical sample.

However, closer examination of this literature indicates that the outcomes most consistently associated with experiencing are symptom-focused or relational in nature, rather than indicators of longer-term changes in self-structure. Most studies assess change using measures of symptom severity, distress reduction, or alliance quality, which are more proximally linked to emotional processing within sessions. In contrast, authenticity reflects a broader and more enduring reorganisation of the self, involving reduced alienation and increased alignment between experience, awareness, and self-concept. From this perspective, it is theoretically plausible that experiencing facilitates immediate therapeutic engagement and emotional resolution without necessarily producing incremental changes in authenticity beyond those already underway.

Process research further indicates that the relationship between experiencing and outcome is temporally patterned rather than uniform across therapy. Pos et al. (2003) found that early experiencing accounted for variance often attributed to early alliance, whereas later experiencing independently predicted symptom improvement. Similarly, Pos et al. (2017) reported that peak experiencing during the middle phase of therapy was most strongly associated with positive outcomes at termination. These findings suggest that experiential engagement becomes therapeutically consequential once clients can attend inwardly, symbolise felt experience, and work with emotional material in an integrative manner, rather than operating as a simple linear predictor in which deeper experiencing invariably leads to better outcomes.

Research has also consistently demonstrated substantial individual differences in clients' initial capacity for experiencing. Klein et al. (1986) observed wide variation in openness to inner experience at the outset of therapy, a finding supported by later studies showing that clients with a greater propensity for experiencing are more likely to deepen their experiential engagement as therapy

progresses (Goldman et al., 2005; Pos et al., 2003; Pos et al., 2009). These differences reflect variation in clients' readiness to access and symbolise felt experience, consistent with Rogers' view that individuals enter therapy at different levels of alienation or congruence.

Beyond depression, the EXP has been examined more selectively in other clinical contexts, including couple therapy and trauma. For example, Makinen and Johnson (2006) found that conflict resolution in couples therapy was associated with deeper levels of experiencing, while Harte (2019) highlighted the role of emotional experiencing in trauma resolution through a case study design. However, these studies are characterised by small sample sizes and heterogeneous outcomes, limiting the generalisability of findings and underscoring the need for larger-scale, longitudinal research examining how experiencing relates to different forms of therapeutic change.

In conclusion, the literature suggests that while experiencing is a central and theoretically meaningful process variable, its association with outcome is contextual, phase-dependent, and outcome-specific. The absence of a direct association between experiencing and later authenticity observed in the present study is therefore consistent with both the broader empirical literature and a person-centred theoretical framework. Authenticity appears to develop primarily through sustained exposure to the therapist's conditions, with experiencing reflecting the client's receptivity to these conditions and the manner in which the AT becomes expressed over time, rather than functioning as an independent mechanism producing later change in self-structure.

3.4 The Present Study

Empiricism strongly influenced Rogers' theory of personality and interpersonal relationships, grounding his work in a scientific approach to psychotherapy research (O'Hara, 1995). A central shift attributed to Rogers and his collaborators was a movement in psychotherapy research away from determining whether therapy works toward understanding how constructive growth unfolds within therapy (Rogers et al., 1967). Rogers' position was explicitly process-oriented, locating psychological movement within the ongoing relational and experiential engagement between client and therapist rather than in discrete outcomes measured at treatment completion. Although psychotherapy effectiveness is now well established, largely due to factors common across approaches such as the therapeutic relationship (Norcross, 2018), outcome-focused designs provide limited insight into the mechanisms through which such movement emerges. Goldfried and Wolfe (1996) highlighted this limitation, arguing that an emphasis on outcome constrains theoretical development and calling for greater attention to therapeutic process and mechanism. From a methodological standpoint, Murphy (2017) discussed the potential to investigate how therapeutic factors may be influenced by other variables, such as the extent to which earlier psychological adjustment is associated with later adjustment in therapy. Murphy and Cramer (2014) further underscored the importance of accounting for prior levels of the same variable when modelling longitudinal trends. Together, these positions point to the necessity of designs capable of capturing therapy as a dynamic process rather than as a static endpoint.

The primary gap in PCT research lies in the absence of longitudinal studies capable of empirically examining a sequential pathway linking relational conditions, client processes, and later personality functioning within a unified

model. Although Rogers (1957) and Barrett-Lennard (1998) outlined such a sequence theoretically, studies that capture early, middle, and later phases of therapy remain uncommon. While experiencing is reliably associated with favourable therapeutic functioning, and therapist-provided empathy and related relational conditions appear to support deeper engagement with inner experience, it remains unclear how these elements are organised prospectively. Existing research has not established whether experiencing operates as an intermediary process, a reciprocal influence, or a characteristic manner of engagement that shapes responsiveness to the therapeutic relationship. Much of the available evidence relies on cross-sectional associations, alliance-based measures that overlap conceptually with person-centred constructs, or outcome-focused designs that obscure the proposed sequence. Addressing this gap requires a design that separates relational perception from in-session process, respects Rogers' non-directive ontology, and examines whether early perceptions of the therapist's conditions are associated with later movement toward authenticity.

Despite the growing body of research using the B-LRI, the empirical base remains fragmented and varies widely in how the measure has been applied. As reviewed in Chapter 2, studies differ in whether psychological contact is established, whether client incongruence is demonstrated, and how perception of the therapist's conditions is operationalised. In many cases, key elements of Rogers' six necessary and sufficient conditions are omitted or examined in isolation. As a result, the literature has not yet examined Rogers' theory as an integrated relational sequence, leaving his central proposition only partially explored.

The present study extends existing process-oriented research by examining Rogers' six necessary and sufficient conditions as a temporal sequence

rather than a set of static relational correlates. Specifically, it is the first study to empirically examine Rogers' proposed pathway linking clients' perceptions of the three therapist conditions, experiential process, and later personality functioning within a single longitudinal design. By modelling these domains across time, the study addresses a long-standing gap in person-centred research and allows their directional pattern to be examined (Watson, 1984).

Research on the three therapist conditions, experiencing, and authenticity has consistently demonstrated their independent associations with positive therapeutic functioning (e.g., Elliott et al., 2018; Farber et al., 2018; Kolden et al., 2011; Pascual-Leone & Yeryomenko, 2017). However, these constructs have rarely been examined together in a manner that permits their sequential pattern to be tested within an integrated model. From a person-centred perspective, experiencing reflects the form the client's internal process may take once a facilitative relational climate is perceived. The quality of the therapeutic relationship is sufficient to release the client's AT. Experiencing, therefore, does not represent a competing pathway, but the client-side expression of relational conditions over time. When these conditions are perceived and received by the client, they may be adequate in themselves to evoke forms of experiential engagement associated with constructive personality direction. Experiencing renders this process observable as clients turn inward, symbolise felt meanings, and reorganise aspects of the self, reflecting how clients make use of the relational conditions provided.

A related issue concerns the positioning of authenticity within the existing literature. Across contexts, authenticity has been conceptualised as a precursor to well-being, as an indicator associated with relational conditions, or as part of a reciprocal process, leaving its directional role unclear (e.g., Boyraz et al., 2014; Proctor et al., 2015; Barrett-Lennard, 1998; Knoll et al., 2015). Moreover,

relatively few studies specify the internal process through which relational conditions are translated into later authenticity within therapeutic settings (Rogers, 1957; Barrett-Lennard, 1998). In response to these limitations, the present study does not assume a fixed causal position for authenticity. Instead, authenticity is examined as a later indicator of personality organisation, while the client's manner of experiencing is modelled as the process through which early relational perceptions may be associated with greater alignment between the client's self-concept and organismic experience

To address the limitations of cross-sectional research in person-centred therapy, the present study adopts a longitudinal design examining interpersonal processes associated with movement toward psychological growth over time. Using data from the HFP, cross-lagged panel modelling (CLPD) provides an appropriate framework for bringing Rogers' six conditions into a single model. This approach moves beyond simple associations by accounting for prior levels of each construct and allowing the proposed sequence to be examined (Selig & Little, 2012). Conditions 1 and 2 are treated as prerequisites within the HFP context, Conditions 3 to 6 are operationalised through clients' perceptions of the therapist's conditions, and authenticity is examined as a later directional indicator. In this way, the principal study variables are modelled within a single framework, offering a probabilistic examination of Rogers' hypothesis that the therapist's conditions facilitate movement toward greater congruence over time (Rogers, 1961).

Finally, mediation analysis is used to examine whether the observed temporal pattern is consistent with the proposed theoretical sequence, namely that experiencing functions as a process variable linking relational perception and later authenticity. Rather than imposing a linear causal explanation, mediation is used to evaluate whether the ordering of variables aligns with the

developmental direction proposed within Rogers' theory (MacKinnon et al., 2007). Taken together, the combined use of CLPD and mediation provides a coherent and theory-driven evaluation of the pathway from relational perception, through experiential process, to constructive personality development.

Aims and Hypotheses

(a) Early B-LRI scores will predict later levels of authenticity, after accounting for earlier levels of authenticity, and

(b) this effect will be mediated by clients' level of experiencing during mid-phase therapy.

3.5 Conclusion

In conclusion, this longitudinal study brings together the B-LRI, the EXP, and the AS to examine how clients' early perceptions of the three therapist conditions are associated with later therapeutic processes and personality outcomes. Pos et al. (2009) showed that clients' levels of experiencing differ across the early, middle, and later phases of therapy and that these variations are associated with differences in therapeutic outcomes at each stage. These findings support the view that experiencing is a developmental process that unfolds within the therapeutic relationship and contributes to outcomes over time. Building on this work, the present study examines this developmental process within Rogers' framework of the six necessary and sufficient conditions for constructive personality change by investigating whether clients' experiential engagement during the middle phase of therapy is temporally linked to earlier perceptions of the therapist's conditions and to later levels of authenticity. Using the HFP dataset, the study allows this proposed sequence to be examined longitudinally, enabling an assessment of whether relational perception precedes changes in experiential engagement and whether these processes are associated

with subsequent movement toward greater authenticity in a manner consistent with Rogers' formulation.

At the same time, the study acknowledges the methodological challenges inherent in longitudinal psychotherapy research. Establishing temporal ordering and directional relationships in therapy is constrained by client attrition, variability in session attendance, and ethical limits on repeated measurement, making causal inference particularly complex in naturalistic settings. The HFP provides a rare research context in which these challenges can be addressed, such as its structured session sampling, repeated administration of theory-consistent measures, and availability of session recordings, which allow relational, process, and outcome variables to be examined across meaningful phases of therapy without disrupting the therapeutic process. This makes the HFP especially well-suited to testing Rogers' hypothesis within a person-centred framework, offering a methodologically rigorous yet theoretically faithful context in which the proposed sequence of relational conditions, experiential process, and personality change can be examined over time.

The following chapter sets out the epistemological and methodological foundations of the present study. It situates the research within a *neo-positivist epistemology* and explains how this epistemological position informs the choice of a longitudinal research design, the selection of measures, and the analytic strategies used to examine Rogers' six necessary and sufficient conditions. The chapter outlines how relational perception, experiential process, and authenticity are operationalised and examined over time within the HFP dataset and justifies the use of quantitative and longitudinal methods to test the proposed temporal sequence in a rigorous, theory-consistent manner.

Chapter 4: *Methodology: Testing the Necessary and Sufficient Conditions*

4.1 Introduction

This chapter describes the methodological approach used to examine temporal and process-oriented associations between clients' earlier perceptions of the three therapist conditions and their later authenticity across time. The chapter also introduces the analytic strategy, including longitudinal and mediation analyses, which are used to explore how clients experiencing may function as a process variable linking the relational conditions to outcomes.

The thesis is based on a secondary analysis of the Human Flourishing Project (HFP) clinical database, which provides naturalistic data from ongoing therapy. Repeated self-report measures and audio recordings allow the investigation of relational, experiential, and outcome variables.

The chapter proceeds by outlining the methodological paradigm and overall research design, followed by a detailed description of the sample, data preparation, and analytic procedures used in subsequent analyses.

4.2 Methodological Paradigm

4.2.1 Testing Sufficiency and Necessary

Selecting a methodological paradigm is a theoretical decision that determines what kinds of claims can be meaningfully examined and how psychological phenomena are to be understood (Crotty, 1998). Research paradigms consist of interrelated assumptions about reality, knowledge, and inquiry that jointly structure empirical investigation (Filstead, 1979; Guba, 1990).

The present study adopts a critical–realist ontology grounded in a humanistic understanding of the person, consistent with Rogers's view of the individual as an organism whose experiences represent genuine aspects of reality (Rogers, 1951). Experiences and relationships are treated as real phenomena that exist independently of the researcher, yet can only be accessed through the client's subjective perception. This stance is critical because it acknowledges that such psychological realities—empathy, congruence, unconditional positive regard, and authenticity—cannot be directly observed. They are latent, unseen forces whose existence is inferred through their observable effects. Rogers's conditions cannot be seen, but their presence is known through the vitality they sustain in the client's movement toward authenticity and congruence. When these conditions are absent, growth falters, much as an organism deprived of oxygen cannot flourish.

Building on this ontological position, the study is guided by a neo-positivist epistemology, which assumes that reality exists independently of perception but can only be approximated through empirical observation and theoretical reasoning. This view balances the positivist pursuit of objectivity with the recognition of human interpretive limits. Rogers's theory of personality (1951, 1959) aligns with this stance: while phenomenological at its core, his work demonstrated that subjective experience can be studied scientifically.

In the present study, these assumptions are not adopted abstractly but are dictated by the logical form of the claim under examination: Rogers's hypothesis that specific relational conditions are necessary and sufficient for constructive personality change.

Rogers (1957, 1959) articulated this hypothesis as a causal proposition. He asserted that empathy, congruence, and unconditional positive regard do not merely accompany therapeutic change but actively facilitate developmental

movement when they are perceived by the client. Crucially, this claim is formulated jointly. The six conditions are described as necessary, in that constructive personality change cannot occur in their absence, and sufficient, in that no additional therapeutic factors are required beyond their presence (Rogers, 1957, 1959). This joint formulation imposes a stringent logical constraint: if either necessity or sufficiency cannot be examined coherently, the hypothesis cannot be tested in the form in which it was originally proposed (Verschueren et al. 2004).

The central challenge is therefore epistemological rather than theoretical. Demonstrating strict necessity would require evidence that constructive personality change never occurs in the absence of the six conditions, a requirement that cannot be satisfied ethically or empirically in psychotherapy research. This does not weaken Rogers's theory; it clarifies the terms under which it can be examined. Psychological causation operates probabilistically, not deterministically. Accordingly, the present study is grounded in a critical realist ontology, which treats relational attitudes and authenticity as real psychological mechanisms that exert causal influence, despite not being directly observable. Their operation must therefore be inferred through patterned effects unfolding over time within the therapeutic process.

On this basis, the study adopts neo-positivist epistemology. Psychological reality is assumed to exist independently of the observer, yet access to that reality is necessarily partial and mediated through empirical indicators and theoretical models (Park et al. 2020). Subjective experience is treated as a real and causally relevant phenomenon rather than a purely interpretive construction. However, its empirical examination requires operationalisation, measurement, and longitudinal modelling, with causal inference understood in terms of

increased likelihood and temporal precedence rather than deterministic implication.

This epistemological stance is not imposed on Rogers's theory but is already implicit within it. Although phenomenological in orientation, Rogers did not regard subjective experience as resistant to scientific inquiry. Instead, he positioned the client's perception of the therapeutic relationship as the primary empirical locus of change (Rogers, 1951, 1959). Substantial empirical evidence demonstrates that clients can perceive, internalise, and articulate the therapist's relational attitudes (Barrett-Lennard, 1997; Fosha, 2001; Kennedy-Moore & Watson, 1999; Vanaerschot, 1990), establishing client-reported data as a legitimate and necessary basis for examining therapeutic process. As Joseph (2015) argued, this focus represented a decisive shift in psychotherapy research away from external ratings toward the systematic study of relational experience as lived.

Within this framework, Rogers's hypothesis is treated as causal in structure but probabilistic in operation. Constructive personality change is conceptualised as a genuine developmental process facilitated by the client's actualising tendency rather than by direct therapist action. Neo-positivism provides methodological conditions under which such a process can be examined without collapsing into either deterministic overclaiming or purely interpretive description. It permits the six conditions to be investigated as components of an integrated relational pathway unfolding across time.

Accordingly, the methodological position adopted in this study is not a compromise between competing paradigms, but a methodological necessity imposed by the theoretical claim itself. A critical realist ontology, combined with a neo-positivist epistemology, provides the only coherent framework within which Rogers's six necessary and sufficient conditions can be empirically

examined as a directional and probabilistic pathway toward constructive growth, without reducing the theory to either a purely interpretive account or a simplistic causal model.

4.3 Research Strategy

The reasoning underpinning this study is deductive. It begins with Rogers's (1957, 1959) proposition that constructive personality change occurs only when specific relational conditions are present and examines whether this proposition can be empirically observed in longitudinal clinical data. Rather than generating theory from the data, the study tests whether the relational and developmental sequence proposed by Rogers is detectable over time.

Addressing this question requires a design that can capture the direction as it unfolds in therapy. A quantitative, quasi-experimental, longitudinal approach was therefore adopted to examine relationships among clients' perceptions of the therapist's conditions (B-LRI), their level of experiencing (EXP), and their self-reported authenticity (AS). Randomisation and experimental manipulation are neither feasible nor ethical in psychotherapy research; consequently, the design prioritises temporal ordering and ecological validity within routine clinical practice.

Treating Rogers's hypothesis as an empirical claim immediately raises a methodological challenge. Analytic strategies that collapse time or focus on concurrent relations cannot address this structure.

To examine this sequence, analytic methods must meet three requirements. First, they must preserve temporal order, allowing earlier perceptions to be distinguished from later outcomes. Second, they must model the direction beyond stability, ensuring that observed associations are not driven

by prior levels of the outcome. Third, they must allow the influence of relational conditions to be examined through a theoretically relevant process variable rather than as an isolated effect.

Single-timepoint correlations and isolated regression models cannot meet these requirements. Although such approaches may identify predictors, they cannot establish whether earlier perceptions precede later change once baseline levels are controlled. As a result, they remain insufficient for testing a hypothesis formulated as a conditional, temporally ordered process.

Rogers's hypothesis is therefore tested here using a longitudinal analytic framework that preserves sequencing and models the direction over time. The combined use of cross-lagged panel design (CLPD) and mediation analysis allows temporal precedence to be evaluated while examining whether the influence of early perceived relational conditions operates through the client's level of experiencing. Together, these methods provide a coherent strategy for examining the temporal sufficiency proposed in Rogers's six necessary and sufficient conditions.

4.3.1 Cross-Lagged Design

According to Kenny (1975), the CLPD tests temporal direction by estimating reciprocal cross-lagged paths between constructs across time while controlling for their prior levels through autoregressive paths. Selig and Little (2012) further emphasise the importance of specifying all relevant temporal associations to avoid misleading interpretations. Accordingly, both autoregressive and cross-lagged paths were specified to account for temporal stability within each construct, allowing later authenticity to be interpreted as change beyond baseline consistency. Paths from earlier authenticity to later perceptions of the therapeutic relationship were also included, despite not being

theoretically expected, to test for spuriousness arising from reverse causation or shared temporal stability.

Assumptions of the CLPD

The CLPD requires repeated, synchronised, and stationary measurements taken at the same time points (Kenny, 1975). Synchronicity treats variables measured within the same wave as contemporaneous indicators of the same developmental moment, reducing temporal bias. In the present study, this assumption was supported by aligning B-LRI, AS, and EXP assessments within the same therapy sessions. Stationarity assumes that the structural relations among variables remain stable across the time horizon examined, ensuring that observed associations reflect developmental processes rather than artefacts of inconsistent timing or measurement conditions.

This structure allows the model to evaluate unidirectionality—whether earlier perceptions of the therapeutic relationship predict later levels of authenticity; reverse directionality, in which earlier authenticity predicts later perceptions of the therapist's conditions; or bidirectionality, in which both directions operate concurrently. Autoregressive paths are central to addressing spuriousness, as an apparent association between B-LRI and authenticity may disappear or reverse once prior levels are controlled. Rather than assuming that one variable causes another, the CLPD evaluates whether earlier variables reliably predict later outcomes under conditions of temporal control. Only when the path from earlier B-LRI to later authenticity remains after these controls can the association be interpreted as directionally consistent with Rogers's proposed temporal ordering. Authenticity at the later time point was therefore interpreted as a later level of authenticity rather than as a measure of change.

While the CLPD distinguishes between unidirectional and bidirectional temporal patterns, it cannot determine whether any remaining association reflects a meaningful psychological process or merely a residual temporal link. Within Rogers's framework, early client perception is not sufficient to promote development unless it is taken up experientially by the client. Mediation analysis therefore constituted a further test at the level of process. As Jose (2016) noted, many mediation analyses rely on single-occasion datasets and assume variable ordering rather than establishing it empirically. For this reason, the CLPD was first applied to the HFP longitudinal dataset to establish whether early client perceptions of the therapist's three conditions temporally precede later authenticity before proceeding to mediation analysis. Mediation analysis was then used to examine whether this temporally ordered association operates through the client's level of experiencing, or whether the association between early perception and later authenticity remains unexplained once process is modelled.

4.3.2 Mediation Analysis

Mediation analysis has been used in psychological research to examine the relationship among three variables (Cole & Maxwell; Jose, 2016; Mackinnon et al., 2007; Selig & Preacher, 2009). This allows measuring the sequential development of authenticity. According to Mackinnon et al. (2007), in mediation analyses, a third variable (Z) adds to the relationship between X and Y, where X influences the mediator (Z), and Z then influences the outcome (Y). Mediation analysis evaluates whether the association between early relational perception and later authenticity is transmitted indirectly through experiencing, rather than reflecting a direct or incidental association. However, indirect effects can also arise from alternative explanations, including unmeasured confounding, parallel

change, or moderation (see Baron & Kenny, 1986; Kraemer et al., 2001; Robin & Greenland, 1992). Confounders can generate apparent pathways that do not reflect actual mechanisms; covariance can show that variables move together without indicating why; moderators influence the strength or direction of relationships but do not form part of the causal chain. For this reason, mediation findings must be interpreted cautiously and situated within a broader temporal framework.

Several longitudinal mediation approaches were considered. The mediation model (Baron & Kenny, 1975; Mackinnon et al., 2007), for example, assumes that changes in the mediator lead to changes in the outcome between two-time points (T1 and T2). Another option is the autoregressive model (Gollob & Reichardt, 1991), which assumes a single path wave between variables. Another type of mediation analysis is latent growth modelling (LGM) (Muthen & Curran, 1997), which examines the paths between variables and accounts for both direct and indirect effects.

The autoregressive mediation approach proposed by Gollob and Reichardt (1991) was selected because it allows change in the mediator to be tested as a predictor of subsequent change in the outcome while controlling for prior levels. Traditional mediation models are typically applied to cross-sectional or single-occasion data and rely on theoretically assumed ordering rather than empirically established temporal precedence, limiting their capacity to examine developmental sequences (cf. Jose, 2016). The single-path specification of the autoregressive model avoids the reciprocal assumptions required by cross-lagged designs and is therefore more appropriate for testing a directional process. Although latent growth modelling would offer a stronger test of mediation, it was not feasible due to sample size constraints. Accordingly, the mediation model follows the temporal sequence: early perception (x) → mid-therapy

experiencing (z) → later congruence (y)into one single wave. This helps determine whether experiencing operates as the mechanism that links perceived therapist conditions to later authenticity rather than the relationship occurring by chance.

Therefore, mediation analysis complements the CLPD. While the CLPD tests whether the association between perceived therapist conditions and authenticity is unidirectional rather than reciprocal, mediation examines whether this directional association operates through a theoretically meaningful process variable. Accordingly, findings from both the CLPD and mediation analyses are interpreted probabilistically, reflecting patterned temporal associations rather than deterministic causal mechanisms. The following section, therefore, outlines the time span of the HFP database and its implications for longitudinal modelling.

4.3.3 Time Horizon

The time horizon of this study is determined by the structure of the HFP database and the organisation of therapy delivery within it. The HFP database contains 535 client entries with repeated session-level measures of the B-LRI and the AS, alongside audio recordings of therapy sessions. Within the HFP, therapy is organised around an initial block of 20 weekly sessions, corresponding to a treatment duration of 20 weeks, which constitutes the normal termination phase of therapy. Clients may elect to continue therapy beyond this point by entering a subsequent block; however, Session 20 marks the termination of the initial therapeutic episode and defines the upper bound of the time horizon examined in the present study. Clients may also discontinue therapy prior to termination. As a result, the dataset is dense in early therapy and progressively smaller at later stages.

More than 300 clients contributed complete B-LRI, AS, and audio data through Session 10, whereas only 113 remained in therapy through Session 20. For analytic purposes, dropout is defined as discontinuation of therapy prior to the completion of the 20-session (20-week) treatment block. Attrition across sessions reduces the number of complete observation points available for longitudinal modelling, limits the pool of audio recordings available for rating experiencing, and raises the possibility that clients who remain in therapy differ systematically from those who discontinue. The time horizon extending to termination is therefore central to the analytic strategy, as both cross-lagged and mediation analyses require sufficient temporal separation to distinguish directional influence from stability or contemporaneous association. Restricting the time horizon to Session 10 would weaken both tests by collapsing temporal order and limiting the capacity to examine process. This is because constructive personality change is not expected to follow immediately from early perception, but to emerge gradually through repeated relational exposure and experiential uptake over time (Rogers, 1959).

In addition to considerations of sample density and attrition, session selection was constrained by core design assumptions of stationarity and synchronicity. Client-reported measures of the therapeutic relationship (B-LRI) and authenticity (AS) were required to correspond to the same therapeutic encounter from which the audio recording was drawn, with all measures collected on the same day. This requirement ensured that clients were assessed at comparable stages of therapy and preserved temporal coherence between client perception, experiential process, and outcome.

Within the HFP database, this alignment occurs only at Sessions 5, 10, 15, and 20. These sessions, therefore, define the feasible time horizon for longitudinal analysis, as they are the only points at which repeated self-report

measures and audio recordings are collected simultaneously. Testing temporal sufficiency requires observation points that span early perception, mid-therapy engagement, and functioning at termination. To reflect this process, the following time points were selected:

i. Session 1: baseline for authenticity and EXP
ii. Session 5: early phase
iii. Session 10: mid-phase
iv. Session 15: mid-late phase
v. Session 20: termination phase

Sessions 5, 10, 15, and 20 were selected as the primary analytic time points, with Session 1 retained as a contingent baseline, where required, for authenticity and experiencing only, as the B-LRI is not administered at this time point. This structure ensured that early client perceptions were first assessed at Session 5, with subsequent sessions allowing examination of how these perceptions were maintained or modified as therapy progressed toward termination.

The five-session spacing follows Little et al. (2007), who argued that measurement waves must be spaced widely enough to detect meaningful temporal variation while remaining close enough to preserve coherence across observations. This interval was selected to capture the formation and consolidation of early client perceptions of the therapist's conditions while reducing the risk that important shifts occur between waves and go unobserved. Wider spacing increases the likelihood that later measurements reflect multiple unmeasured transitions rather than a discernible temporal sequence. Therapeutic engagement may also unfold progressively across the course of treatment. Sohal (2022) reported gradual increases in authenticity across 20 sessions, indicating that client evaluations and experiences of the therapeutic relationship may continue to evolve across the full course of therapy, including

the termination phase. This supports the use of multiple observation points rather than reliance on a single early assessment.

After establishing the temporal framework for observing relational, process, and outcome variables, the next section explains how the process measure was assessed within this timeframe.

4.4 Method of Rating Audio Recording

4.4.1 Ethics

Ethical considerations were central to this PhD because it involved the use of clients' therapeutic audio recordings as research data. These recordings contained sensitive and personal material, requiring careful handling during listening, replaying, and interpretation to protect client confidentiality, privacy, and welfare. Ethical approval was granted by the University of Nottingham (UoN) Ethics Committee, and all procedures were conducted in accordance with both UoN standards and the Human Flourishing Project's (HFP) ethical protocols.

All data were securely stored on the HFP SharePoint database, with each client identified by a unique code to preserve anonymity. Anonymisation was achieved through coded filenames, and no identifying information was accessible during analysis. The audio recordings contained clients' and therapists' voices, as well as references to personal difficulties and life histories. In accordance with HFP protocol, all recordings remained on SharePoint and were never downloaded onto personal devices. Access was restricted to authorised users through secure login, ensuring that sensitive material was protected at all stages of the research process.

Care was taken to maintain clear boundaries between therapeutic material and its use for research purposes. Listening to recordings required

professional integrity and sensitivity to clients' experiences, and recordings were discussed only within the supervisory team. No data were shared beyond this context. Breaches of confidentiality could have serious implications for client trust and the integrity of psychotherapy research, underscoring the need for ethical vigilance.

Audio recordings were accessed primarily on UoN premises using a foot pedal and headphones to allow precise control when replaying segments for accuracy. When off-campus access was necessary, the UoN Virtual Private Network (VPN) was used exclusively. The VPN encrypted all data transmissions, reducing the risk of unauthorised access and supporting compliance with institutional data protection requirements.

4.4.2 Rationale for Audio Segment Sampling

Within the mediation outlined in Figure 1.2, the client experiencing (EXP) was operationalised as the central process mediator and assessed through the systematic rating of therapy audio recordings from the HFP database. All recordings were collected and rated prior to exposure to B-LRI or AS results to preserve the independence of the process variable and avoid expectancy bias

The investigator progressed from structured training material to real HFP audio recordings after completing 40 hours of guided calibration exercises using Volumes II and III of the Experiencing Scale manuals (Klein et al., 1986). Although mediation analysis required only a mid-therapy recording (Session 10 or 15), audio from Sessions 1, 5, 10, 15, and 20 was collected to retain the option of longitudinal modelling and to support rater calibration. Audio recordings were available for 113, although some recordings were missing or incomplete. At this stage, no participants had been excluded; the inclusion criteria were that clients had finished a block of 20 sessions

The operationalisation of EXP depends on how therapy recordings are sampled. The EXP manuals recommend segment durations of approximately 2–8 minutes for reliable scoring (Klein et al., 1969). Random sampling was unsuitable for EXP scoring. The first 5–20 minutes of each 50-minute session are primarily devoted to completing session forms, yielding limited therapeutic dialogue. In addition, clients' experiential engagement fluctuates naturally within sessions (Goldman et al., 2005), and early or late segments often focus on organisational or practical concerns rather than sustained therapeutic work. Randomly chosen segments might occur during times when clients are completing the session forms.

For this reason, a purposive sampling strategy was adopted to identify a segment of each session that plausibly reflected sustained experiential engagement while remaining temporally aligned with the other study variables. To maintain consistency across participants and time points, segments were selected at approximately 30 minutes into the session, once the session forms had been completed. This timing allowed clients sufficient opportunity to settle into the therapeutic process and begin engaging more fully. A fixed duration of seven minutes was used, providing enough material to observe variation in experiential engagement while preserving comparability across sessions. Standardising both the timing and length of the segments therefore offered a consistent representation of EXP across the sample.

EXP ratings were based exclusively on the client's verbal expression during the selected segment. Therapist interventions were not included in the scoring but were referred to only when needed to clarify the client's intended meaning. Access to the full session material enabled an accurate understanding of the context; however, steps were taken to minimise the researcher's influence and maintain fidelity to the person-centred frame. This included bracketing

personal reactions, adopting a non-evaluative stance, and remaining fully present to the client's emerging process without referencing their wider difficulties or therapeutic trajectory. Attention remained on the client's verbal expression of their experiencing, staying close to their frame of reference and avoiding interpretative assumptions.

Reliability was established before full scoring commenced. After rating nine clients (45 recordings) across Sessions 1, 5, 10, 15, and 20, the transition from structured training examples to unscripted clinical material introduced new challenges. In the training manuals, each segment is accompanied by a confirmed rating. Once these reference points were no longer available, assigning numerical values to clients' emotional expressions required increased interpretative sensitivity, highlighting the risk of overlooking or overinterpreting subtle experiential shifts.

Establishing reliability at this stage ensured that the process variable rested on a secure foundation before being incorporated into any temporal models. EXP preparation was therefore kept analytically open. Both modal and peak indices were retained, allowing flexibility in subsequent modelling decisions while ensuring that all EXP indices were derived from the same standardised, temporally aligned scoring procedure.

Once satisfactory agreement was achieved, full scoring resumed. From the initial pool of 113 clients, 70 clients (350 recordings) were rated without further transcriptions. This approach maximised participant retention while maintaining confidence in the consistency and quality of the EXP variable, strengthening the basis for subsequent analytic decisions.

Each audio file was reviewed to distinguish between administrative activity and the onset of therapeutic dialogue. Verbal cues such as tone shifts,

topic changes, and the absence of paper sounds were used to identify the transition point. When clients completed the HFP booklet before recording, the first minute was treated as the start of therapy, and the 30-minute mark was used to select the 7-minute segment. Where form completion occurred during the recording, the audio was reviewed to identify its conclusion, although overlap between administrative and therapeutic material was sometimes observed.

Recording length further influenced segment selection. Longer recordings (over 40 minutes) typically captured middle-to-late phases of therapy, whereas shorter recordings (under 30 minutes) often contained only closing interactions. To accommodate this variability, recordings were categorised as long or short, and tailored selection rules were applied. When the 30-minute mark was not reached due to extended form completion, EXP was rated later in the session, once continuous therapeutic dialogue of at least 2 minutes was evident. For shorter recordings, segments were selected manually to ensure at least five minutes of meaningful therapeutic interaction. Table 4.4 summarises the segment-selection rules applied across audio recordings.

Table 4.1: Description of Rules for Clients' EXP

Rule	Application	N=
5-Minutes Segment Rule	Applied when a recording exceeded 40 minutes, but the client took over 20 minutes to complete the booklet.	**For 2 audio Recordings**
25-Minutes Point of Rating Rule	For short recordings, the analysis segment began at the 25-minute mark to avoid the session's final minutes.	**For 5 audio Recordings**
Last 7-Minute of Audio Recording Rule	Applied when sessions were shorter than 20 minutes. The last 7 minutes of the recording were used for analysis.	**For 7 Audio Recordings**

Note. N=70; EXP=Experiencing Scale

4.5 Data Sampling

Meeting the assumptions of stationarity and synchronicity directly guided the participant-selection process. These analytic requirements shaped the sampling design, introducing quasi-probability features while the overall approach remained purposive and criterion-based. Although the HFP dataset represents a naturally occurring clinical population, inclusion was determined by clear, objective criteria necessary for longitudinal modelling, including completed session forms, functional audio recordings, and compatibility with CLPD assumptions. As a result, the sampling design was primarily non-probability, shaped by methodological requirements rather than randomness. Only clients who completed their B-LRI and AS forms on the designated sessions (Sessions 1, 5, 10, 15, and 20) were retained. This approach prioritised temporal accuracy and internal validity over representativeness.

Exclusions occurred when required forms were missing, completed outside the designated session windows, or could not be reliably aligned with corresponding audio recordings. Additional exclusions reflected protocol violations, including the use of non-comparable B-LRI versions, duplicate records from returning clients, and inconsistencies that compromised stationarity or synchronicity. Table 4.5 summarises the exclusion process. After applying the assumption of the CLPD, 54 clients were excluded from 113 who completed 20 sessions.

Table 4.2: Participant Exclusion Process

Step	Description	Participants Excluded	Participants Remaining
Initial Sample	-	-	113
Exclusion 1	Clients with missing therapy sessions of B-LRI & AS	22	91
Exclusion 2	Clients who did not complete both or one session forms on the exact day of sessions 1, 5, 10, 15, 20	7	84
Exclusion 3	Entries without physical copies of client data	2	82
Exclusion 4	Clients who filled B-LRI regarding someone other than the therapist	2	80
Exclusion 6	Clients removed due to inconsistencies with audio recordings	2	78
Exclusion 7	Returning clients with duplicate or triplicate folders	10	68
Exclusion 8	Clients who filled out a shorter version of the B-LRI	9	**59**
Exclusion 9	Clients who have missing audio recordings	19	**40**

Note. The final CLPD dataset consisted of 59 clients who met all assumptions of stationarity and synchronicity. When the Experiencing Scale (EXP) was introduced, a refined subsample of 40 clients was used, reflecting those with complete, high-quality audio data suitable for process analysis

59 met the requirements for CLPD analyses between B-LRI and AS. These clients were associated with 28 therapists; however, therapist inclusion was

incidental, as clients constituted the primary unit of analysis. When the Experiencing Scale (EXP) was introduced as a process variable, further refinement became necessary because EXP depends on complete, high-quality audio recordings from the same sessions in which B-LRI and AS were completed. As shown in Table 4.6, 19 clients had missing or unusable recordings, resulting in a final EXP sample of 40 clients across 19 therapists. This reduction reflects data availability within the HFP alongside the methodological requirement to retain a sample consistent with CLPD assumptions. Although smaller, the resulting sample remains representative of clients who met the longitudinal and temporal requirements of the model and provides an internally consistent basis for testing directional hypotheses within the CLPD framework.

Table 4.3: Missing Audio Recordings

Missing Audio Recording	Total
Session 1	3
Session 5	2
Session 10	5
Session 15	2
Session 20	4
Too Short (< 8 minutes)	3

n=19; Note. 19 clients had missing audio recordings

Accordingly, the final samples (N = 59 for CLPD; N = 40 for mediation) represent purposive, criterion-based subsets of clients who consistently engaged in person-centred therapy within the HFP setting. While not statistically generalisable to broader populations, these samples are theoretically

appropriate for examining relational, process, and outcome pathways within a longitudinal design.

4.6 Data Collection

The data collection for this thesis took place from 2017 to 2020 from HFP database. Three standardised measures were used at different stages of the therapeutic process in this study: a relational measure (B-LRI-OS 40), a process measure (EXP), and an outcome measure (AS). Each instrument served a specific role within the model, representing the relational, process, and outcome variables, respectively, within Rogers six necessary and sufficient conditions for constructive personality change.

Within the HFP, the prerequisite conditions for constructive personality change are inherent to the therapeutic context itself. Psychological contact (Condition 1) is demonstrated through the provision of face-to-face therapy, in which therapist and client are in direct relational engagement. Client incongruence (Condition 2) is implicit in participation in therapy, as clients present in a state of vulnerability that reflects a lack of alignment between experience and self-structure. The B-LRI assesses the client's perception of the therapist's congruence, empathy, and unconditional positive regard (Conditions 3–5), as well as the client's perception of these attitudes (Condition 6). EXP functions as the process variable, illustrating how clients internalise and engage with these perceived therapist attitudes through their organismic valuing process. Later levels of authenticity is then indexed using the AS, which captures shifts from alienation toward increased congruence over time. Table 4.7 presents a selection of HFP sessions across five time points (Sessions 1, 5, 10, 15, and 20).

Table 4.4: Measurement Tools

Purpose	Measures	Data Collected
Demographics	C.O.R. E and Therapists' Information Grid	**Client**: Age, Gender, Ethnicity, concerns, and time duration **Therapists:** gender and number of clients
Dependent Variable	Authenticity Scale	Sessions: 5, 10, 15 and 20
Independent Variable	Barrett-Lennard Relationship Inventory	Sessions: 5, 10, 15 and 20
Mediator Variable	Experiencing Scale	Sessions: 5, 10, 15 and 20

Note. C.O.R.E. = Clinical Outcomes in Routine Evaluation

4.6.1 Demographic Information

Appendix 8 presents the demographic and administrative items used to characterise the sample and describes the sources from which this information was obtained. Demographic and background data were drawn from the intake form, which is completed jointly by therapists and clients during the intake

session at the HFP. As none of the primary study instruments included demographic items, the Clinical Outcomes in Routine Evaluation (CORE) form was used solely to extract basic background information, including clients' age, gender, ethnicity, and presenting concerns (e.g., depression, anxiety, addiction, relationship difficulties, and self-esteem concerns). The CORE was not used as an outcome or process measure in the present study.

Administrative information was also obtained from HFP records. Each client was assigned a unique, anonymous numerical identifier (ranging from 1 to 550), and therapists were identified by initials only. Information regarding the duration of therapy was extracted from the HFP information grid, which records therapist entries across sessions.

4.6.2 Relational Measure

Appendix 1 presents the Barrett-Lennard Relationship Inventory – Other-to-Self, 40-item version (B-LRI-OS 40; Barrett-Lennard, 2002), along with the scoring procedures and item composition. The B-LRI was used to assess clients' perceptions of the three therapists' conditions at sessions 5, 10, 15, and 20. These repeated assessments provided the longitudinal data used to examine clients' earlier perceptions of the therapist's conditions in relation to later phases of therapy.

The measure comprises 40 items equally distributed across four 10-item subscales. Half of the items are negatively worded and are therefore reverse scored, such that higher total scores consistently reflect stronger perceptions of the therapist's conditions. The B-LRI is rated on a 6-point bipolar scale ranging from −3 (*strongly feel that it is not true*) to +3 (*strongly feel that it is true*). When administered face-to-face, clients answered each item with a specific therapist in

mind, allowing both positive and negative perceptions of the therapist's relational attitudes to be captured within the same instrument.

Scoring involved first reversing the five items within each subscale. Once 20 items had been reverse-scored, the full set of 40 items was summed to produce a total score ranging from −120 to +120. Higher scores indicate stronger perceived empathy, congruence, and unconditional positive regard, whereas lower scores indicate that the therapist was perceived as less able to convey these conditions effectively. The total score represents the client's perception of the quality of the therapeutic relationship.

4.6.3 Outcome Measure

Appendix 6 presents the Authenticity Scale (AS; Wood et al., 2008), along with the scoring procedures and item composition. The AS was used to assess clients' self-perceived authenticity at sessions 1, 5, 10, 15, and 20. The AS represents the outcome variable in which the client's earlier perception of the therapist's conditions, and the manner in which these are received and experienced through an inward experiential focus, are reflected in later levels of authenticity.

The scale comprises 12 items rated on a seven-point Likert scale ranging from 1 (does not describe me at all) to 7 (describes me very well) (see Table 3.1). The AS is divided into three sub-dimensions: authentic living, self-alienation, and accepting external influence, with each subscale comprising four items. When administered within the therapist–client context, clients rate how accurately each item describes themselves. The scale captures individual differences in alignment between the client's self-concept and organismic experience.

Scoring involves reversing 8 items so that higher total scores indicate higher levels of authenticity and lower levels of self-alienation and accepting

external influence. After reverse scoring, responses across the 12 items are summed to produce a total score ranging from 12 to 84. Higher scores reflect lower self-alienation and accepting external influence, and greater authenticity and alignment between self-concept and organismic experience, whereas lower scores indicate greater alienation, higher acceptance of external influence, and lower authenticity.

4.6.4 Process Measure

Appendix 7 presents the Experiencing Scale (EXP; Klein et al., 1969), along with the scoring procedures and *Summary Rating Sheet*. The EXP was used to assess the manner in which clients engage with their emotions during sessions 1, 5, 10, 15, and 20. The EXP provided the process variable that connected perceived therapist conditions (B-LRI) to client outcomes (AS).

Audio-recorded sessions were rated on a seven-point Likert-type scale ranging from 1 (narrative or external description) to 7 (free movement among feelings and meanings), with lower stages indicating externally focused narration and higher stages reflecting emotional engagement, inward reference, and self-exploration. Audio recordings were collected for sessions 1, 5, 10, 15, and 20. When rating client EXP, each client's responses within a selected segment were rated using the *Summary Rating Sheet* from the Experiencing Scale. This rating sheet consists of a single-page grid displaying the seven experiential stages (1–7), each accompanied by a brief descriptive phrase summarising the corresponding level. One seven-minute segment was coded per session. This was taken approximately 30 minutes into the recording to capture the middle–late phase of therapeutic dialogue, where higher levels of experiencing are most likely to occur. These condensed descriptors served as anchor points when assigning ratings. The sheet provides dedicated spaces to record the exact time boundaries of the

selected segment (e.g., “30:00–37:00”) and to mark ratings using the designated symbols.

Scoring involves a trained rater listening to or reading each client segment and assigning ongoing ratings to individual speech turns. This dynamic approach allows the rater to recognise changes in the manner of experiencing as the session progresses. As the rater listens, they focus on moment-to-moment variations in how the client interacts with their felt experience and note points at which apparent shifts in experiential stance occur. These variations are then summarised using two main indices: mode and peak.

Mode experiencing reflects the most consistently observed manner of experiential engagement across the selected segment and was used to represent clients’ sustained way of relating to their felt experience. Peak experiencing captures the highest level of experiential engagement momentarily achieved within the same segment, typically reflected in a brief instance of close contact with felt experience. While peak experiencing may be represented by a single statement, it reflects a qualitative shift in experiential stance rather than emotional intensity per se. Mode and peak experiencing may coincide when clients maintain a consistently receptive and inward manner of experiencing or diverge when brief moments of heightened experiential engagement occur within a more moderate overall pattern.

For instance, if a client expressed no personal connection in their statements (i.e., using fewer "I" statements) and spoke more about others, it was rated either 1 or 2, depending on the narrative. If a client expressed bodily tension (e.g., chest pain), this statement was rated as level 3, while a client's articulation of sadness (e.g., "I feel sad") was rated at level 4. However, if a client develops a deeper connection with their felt sense, their rating could rise from level 4 to higher levels, indicating stronger alignment with their OVP (e.g., "I feel

sad for myself because I am afraid of him"). This alignment reflects a deeper connection to their felt sense, where clients begin to trust their internal locus of control.

4.7 Data Procedure and Analysis

Data processing and analysis followed a staged procedure designed to prepare the HFP dataset for statistical modelling. The initial dataset comprised 535 client entries stored in an Excel database within the HFP SharePoint workspace, containing demographic information and repeated session-level scores for the B-LRI and the AS. Audio recordings of therapy sessions were stored separately in a dedicated folder within the same SharePoint system and linked to clients through identification numbers and session dates. All subsequent analyses, including principal component analyses of the B-LRI and AS, regression models, CLPD, and mediation analyses, were derived from this original pool of clients. Sample sizes varied across analyses because each method required complete data for specific variables, time points, and temporal ordering. This applied to both longitudinal models and principal component analyses, where inclusion depended on item completeness at the relevant session. Each analytic stage, therefore, drew on a dataset refined to meet the assumptions of the method being applied, maximising case retention while ensuring statistical and temporal validity.

4.7.1 Data Cleaning and Preparations

Data cleaning began with the creation of an Excel sheet in the HFP SharePoint workspace, where participant data were organised by client identification number and session order. Session forms for the B-LRI and the AS,

together with audio recordings, were retained for Sessions 1, 5, 10, 15, and 20, as these represented key phases of therapy. The initial screening aimed to determine whether a sufficient sample with complete data across all 20 sessions was available to support longitudinal analyses, such as the CLPD, and to examine later-stage therapeutic development. This process identified 113 clients who had completed all 20 sessions. These cases were retained because they represented extended therapy trajectories suitable for longitudinal analysis.

From this subset, 350 audio recordings were rated for EXP. For each session, two composite EXP scores were manually calculated, representing the mode and peak levels of experiencing (e.g., ModeS5, PeakS5), each ranging from 1 to 7. All audio-related materials and documentation were securely stored within the HFP SharePoint system, with metadata maintained throughout to ensure traceability across analytic stages. Word (.docx) transcripts were prepared for 17 selected recordings, each comprising a seven-minute segment of a therapy session, and an Excel (.xlsx) file documented mode and peak EXP ratings from three independent raters for five clients. Cleaned SPSS (.sav) files contained verified B-LRI, AS, and EXP data for the final audio-based sample (N = 70).

Following completion of the EXP ratings, CLPD assumptions of stationarity and synchronicity were applied. Clients who had completed a shortened version of the B-LRI or appeared as duplicate entries were excluded (see Table 4.4). The temporal sequence of session completion was verified by consulting the HFP information grid to confirm dates and by reviewing audio recordings to ensure that session forms were not completed retrospectively at the end of sessions. After these exclusions, the dataset was refined to 59 clients who met all CLPD criteria. A separate subsample of 40 clients was retained for analyses involving audio data, excluding cases without usable recordings (n = 19).

After the main cleaning phase, demographic information was verified and completed where necessary, including therapy duration. The field of clients' demographic questions was reviewed and recorded where necessary (e.g. adding clients' time duration). Another field of clients' information was kept (e.g. Duration of clients), and others were deleted (e.g. clients' information for over session 20 and clients who filled the shorter version of the B-LRI). Another field of clients' information was saved separately on a different sheet as a potential limitation (e.g. 19 clients did not have their audio recordings). Then in SPSS (V.28) missing values, descriptive, and correlation analyses were conducted in SPSS (v28). Syntax scripts were developed to automate reverse scoring and variable transformations, ensuring that higher values consistently reflected more positive client outcomes. Additional syntax was used to compute total scores for the AS and the B-LRI; this ensured consistency in score construction across sessions and supported comparability in subsequent analyses. EXP scores were then integrated with B-LRI and AS data to construct longitudinal datasets in SPSS and RStudio, which formed the basis for subsequent correlation, regression, and mediation analyses.

Descriptive statistics (i.e., mean, SD, and Cronbach's alpha) were calculated for AS, B-LRI, and EXP variables across various time points. Missing values were addressed using the Missing Value Analysis function (e.g., MCAR), where 74 missing items (out of 10,000) were replaced with the mean. Pearson correlations were conducted between B-LRI, EXP and authenticity across time points. The SPSS file was then exported to Excel to use the same code initially created in SPSS and imported back into RStudio (v4.3.3) for multiple regression, mediation, and cross-lagged analyses.

Syntax scripts were again used in RStudio to code regression models, mediation pathways, and latent variables. Specific R packages were installed and

loaded to perform the statistical procedures required at each stage of analysis. Appendix 9 provides example syntax for each analysis in RStudio, and Table 4.5 lists the R packages used with their corresponding functions.

Table 4.5: Library Tools on RStudio

R Package Tool	Application	Function
haven	Importing/exporting Data	To read & write data
Stats	Shapiro-Wilk test	Test for normality (W statistic)
car	ANOVA	Tests for the change in Δ R^2
lmtest	Performed unstandardized linear and multiple regression analyses.	Tests for the F-statistic whether the change in R^2 is statistically significant.
boot	Bootstrapping	Resampling technique for non-normality
MASS	Applied for Mediation equation.	Pre-requisite function for mediation
sandwich	Applied for mediation	Pre-requisite function for mediation
Mediation	Performed Mediation analysis.	Use to draw the path for mediation Analysis and; To calculate path, a, b, c', and ab
lavaan	Applied for SEM and mediation pathways.	summary (): Provides detailed output of the model fit, including R^2 and statistical significance of predictors.; Coding (fit, standardized = TRUE); to calculate z-values, t-values and confidence intervals.

semTools	Structural Equation Modelling	use to draw the path in the CLPD; To calculate the two cross lagged effect (path a and b)
Scale	standardising the coefficients	to calculate β.

Following data preparation, analyses were conducted sequentially, beginning with descriptive and preliminary analyses and progressing to regression, mediation, and longitudinal modelling where data completeness permitted.

Each analytical stage generated quantitative outputs, including p-values, coefficients, R-squared values, and confidence intervals, which numerically expressed relationships between variables. Throughout the analyses, p-values were used to test null hypotheses and evaluate whether observed associations were unlikely to have occurred by chance (Howitt & Cramer, 2014). A conventional threshold of p less than .05 was used to indicate statistical significance (Fisher, 1925).

4.7.2 Descriptive Statistics

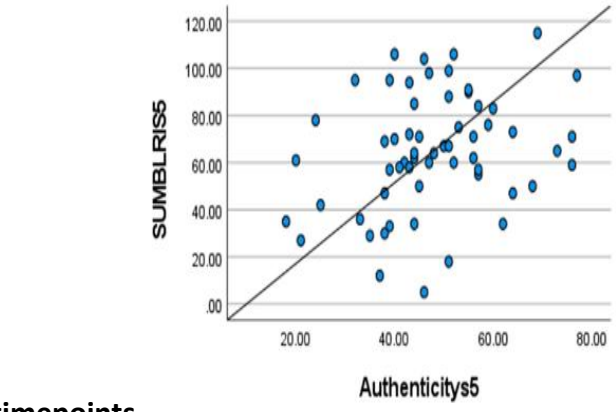
As part of the data screening process, descriptive statistics were conducted to examine the sample characteristics and verify that the dataset met the assumptions required for subsequent statistical modelling. Frequencies were calculated for nominal data (e.g., demographics), while means and standard deviations were computed for continuous variables. Normality was assessed using the Shapiro–Wilk test (W statistic) as presented in Table 4.6.

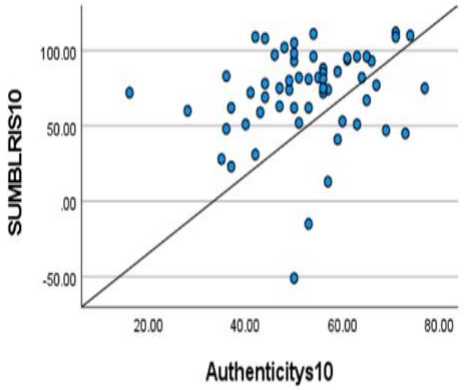
Table 4.6: Normality Test of Authenticity and B-LRI Variables Across Sessions For N=59.

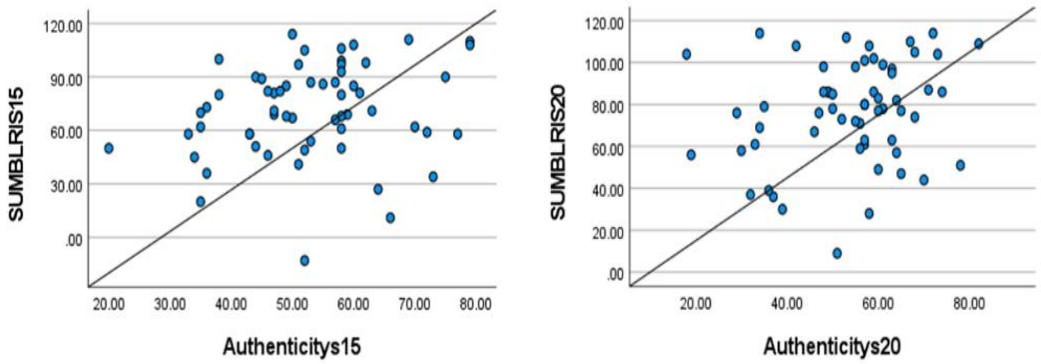
Variable	W Statistics
Authenticity at S1	0.95
Authenticity at S5	0.85
Authenticity at S10	0.91
Authenticity at S15	0.64
Authenticity at S20	0.28
B-LRI at S5	0.45
B-LRI at S10	0.03
B-LRI at S15	0.01
BLRI at S20	0.19

The W statistic ranges from 0 to 1, with values closer to 1 indicating that the data are more likely to follow a normal distribution. Most variables were approximately normal, although B-LRI at sessions 10 and 15 deviated significantly.

Figure 4.1: Scatterplot for N=59 between AS and B-LRI across timepoints







Visual inspection of the scatterplots (Figure 4.1) supported these findings. Most data points aligned with the regression line, but several deviations were observed, suggesting outliers or potential nonlinearity. In psychotherapy research, such deviations are common and often reflect genuine individual differences rather than measurement error. As Cooper (2020) noted, outliers may capture hidden or unmeasured influences—such as incongruence or contextual factors—that contribute to non-normality.

Because of these deviations, conventional parametric methods that rely on normality assumptions were considered unsuitable for subsequent inferential testing. For this reason, bootstrapping will be applied in the subsequent analyses (see Chapter 6). This approach generates new samples by resampling with replacement from the observed data (Efron & Tibshirani, 1994), providing more accurate confidence intervals and standard errors without assuming normality. Bootstrapping is particularly well-suited to small samples, such as the HFP dataset (N = 59), and has been shown to yield stable estimates in regression analysis with sample sizes between 30 and 60 (Wu, 1986; Fisher & Hall, 1991).

Among the available techniques, the percentile bootstrap (without bias correction) was selected for use in this study. This decision followed recommendations by Fritz et al. (2012) and Tibbe and Montoya (2022), who observed that the bias-corrected method can inflate Type I error rates, producing

overly liberal significance levels. The percentile method provides a more conservative and stable inference approach, suitable for small-sample psychotherapy data. The Wald test, which assumes normality of the estimators, was not chosen due to its sensitivity to skewness and limited performance with heterogeneous samples (Phillips & Park, 1988).

In summary, the descriptive analyses presented in this chapter served a preparatory function for subsequent inferential testing. Assessments of distributional properties, missing data, and outliers informed analytic decisions and provided the rationale for the principal component analyses reported in the following chapter.

4.7.3 Preliminary Analysis

The following preliminary analyses were conducted to assess measurement reliability, dimensionality, and temporal feasibility before specifying inferential models.

The preliminary analytical process began by evaluating inter-rater reliability for the experiencing ratings across eight clients, based on 17 audio recordings from Sessions 1, 5, 10, 15, and 20. Agreement among the three raters on both peak and mode experiencing scores was assessed using Spearman correlation analyses conducted in SPSS.

The internal structure of the B-LRI and the AS was examined using principal component analysis to determine whether theoretical subscales proposed in previous research emerged within the HFP dataset or whether each measure functioned as a single coherent construct. Establishing dimensionality was necessary before specifying longitudinal models. Exploratory factor analyses were conducted at two cross-sectional time points, Session 1 for authenticity and Session 5 for the B-LRI. Pearson correlations were used to explore relationships

among variables, and Cronbach's alpha was used to assess internal consistency for the B-LRI (Cronbach, 1951). Factor loadings were considered adequate if they exceeded 0.48 for the B-LRI (Cramer, 1986; Murphy, 2010) and 0.6 for the AS using an orthogonal forced solution. Cartwright et al. (2020) suggest that loadings of 0.6 may be necessary to accurately capture the authentic living subscale, which is particularly relevant given the AS's shorter length. When items formed a single component, total scores were used. When separate components emerged, subscale scores were retained for subsequent modelling.

Then, bivariate correlations and multiple regression analyses were conducted using two sample sizes (N = 59 and N = 40) across Sessions 5, 10, 15, and 20. Cross-lagged correlations (CLC) were conducted in SPSS to describe how associations between the B-LRI and authenticity evolved across sessions. Multiple multiple regression analyses were conducted in RStudio to examine whether clients' perceptions of the three therapists' conditions and authenticity could be modelled across time. Each model followed a two-step analytic procedure. Model 1 was a simple regression testing the direct predictive effect of B-LRI at an earlier time point on authenticity at a later time point. This step provided an initial indication of whether the association was sufficiently robust to warrant longitudinal examination. Model 2 then introduced authenticity at the earlier time point together with concurrent B-LRI, allowing assessment of whether early relational perception retained explanatory value after accounting for stability in authenticity and contemporaneous relational factors. This step clarified whether therapist conditions contributed uniquely to later authenticity or whether observed associations primarily reflected continuity in clients' authenticity levels.

Effect sizes were interpreted using Cohen's conventions (Cohen, 1988), with both unstandardised (B) and standardised (β) coefficients reported.

Variables were standardised using the scale function in RStudio to address differences in scale ranges. B represents the expected change in authenticity at the later time point associated with a one-unit change in B-LRI at the earlier time point, whereas β reflects the relative strength of this association on a comparable metric. The model fit of the regression models was evaluated using R^2 and ΔR^2 values (Cohen et al., 2003) to measure the proportion of variance in later authenticity explained by clients' perception of the three therapist conditions. The R^2 value represents the proportion of variance in later authenticity explained by the model, while ΔR^2 reflects the additional variance accounted for when predictors were introduced in subsequent blocks. The F-statistic was used to test whether each model explained significantly more variance than an intercept-only model, with residual degrees of freedom (df) defining the test distribution. Bootstrapping procedures were implemented using the boot package to address non-normality and small-sample limitations (Efron & Tibshirani, 1994; Hayes, 2018). These analytical steps established a statistically valid and theoretically coherent dataset, suitable for the advanced longitudinal modelling and mediation analyses presented in the next section.

4.7.4 Inferential Analysis

Cross-lagged analyses were conducted using structural equation modelling (SEM) to examine directional associations between clients' perceptions of the three therapist conditions, as measured by the B-LRI, and authenticity across sessions. SEM enables simultaneous estimation of multiple directional paths while accounting for measurement error, with path analysis used to specify longitudinal relationships between constructs. Standardised coefficients were used to evaluate the magnitude and direction of predictive effects (Bring, 1994; Nieminen, 2022; Van Ginkel, 2022).

Potential spuriousness was addressed by including both autoregressive and competing cross-lagged paths within the same model. Autoregressive paths (e.g., B-LRI$_5$ → B-LRI$_{10}$; AS$_5$ → AS$_{10}$) tested within-construct stability, while cross-lagged paths (e.g., B-LRI$_5$ → AS$_{10}$; AS$_5$ → B-LRI$_{10}$) examined directional associations between constructs across time. Parameters were estimated using maximum likelihood (ML), producing standardised path coefficients (β), standard errors (SE), and p-values evaluated at the 0.05 significance level.

Following Kenny (1975, 2024), directional asymmetry between opposing cross-lagged paths was evaluated by testing whether the difference between their regression coefficients significantly differed from zero. This was achieved by converting the difference between the two coefficients into a z value (Δb). Percentile bootstrapping was applied when normality assumptions were not met, and global model fit indices were examined to evaluate the compatibility of the proposed longitudinal structure with the observed covariance matrix, without implying causal sufficiency. Global fit provides a statistically viable representation of longitudinal associations between perceived therapist conditions and authenticity, without implying causal sufficiency. Differences between cross-lagged coefficients were assessed using $\Delta b = b_1 - b_2$, with statistical significance evaluated using a z-test (critical value = 1.96).

The mediation analysis was performed using Unstandardised coefficients (B) and confidence intervals were reported for each pathway to assess the significance and strength of mediation. This method estimated both direct and indirect effects between variables through bootstrapped confidence intervals. The initial step was specifying the model syntax, defining B-LRI as the independent variable (X), EXP as the mediator (Z), and Authenticity as the dependent variable (Y). Each path — *a* (X→Z), *b* (Z→Y), and *c'* (X→Y controlling for Z) — was computed, along with the indirect effect (*a* × *b*). The indirect effect

of B-LRI on authenticity through EXP is calculated as the product of the two paths, represented by (a × b).

4.8 Conclusion

In conclusion, the HFP research clinic provides the setting needed for an integrated longitudinal design that links client-perceived therapist conditions, client process (EXP), and developmental outcome. The HFP provides the methodological conditions for integrating Rogers's six necessary and sufficient conditions with both a process variable and a developmental outcome within a single coherent model.

A quasi-experimental design was adopted to transform clients' relational, process, and outcome data into numerical variables suitable for statistical testing. Representing these constructs numerically enabled the integration of perceived therapist conditions (B-LRI), client experiencing (EXP), and authenticity (AS) into correlational, regression, and CLPD analyses. These analyses quantified the strength and direction of relationships between early therapist conditions, clients' process engagement, and later authenticity outcomes.

Because this hierarchical framework required distinct datasets, the analytic strategy followed a staged sequence. According to Kenny (1975), introducing a third variable into a CLPD requires both theoretical and empirical justification, as it transforms the model from a test of temporal association to a process explanation. In this study, such justification was established through a sequence of preliminary analyses. This layered design reduced the risk of conflating correlation with process explanation by examining whether the observed pattern of relationships was consistent with Rogers's theory of personality. Each analytical stage, including factor analysis, regression, cross-lagged modelling, structural equation modelling, and mediation, was built on the

previous one to create a cumulative and theoretically grounded evaluation of the six necessary and sufficient conditions for constructive personality change. The inclusion of client experiencing was therefore both conceptually motivated and empirically evaluated.

To do this, CLPD will be used to identify directional relationships over time, while mediation analysis will examine whether the association between clients' early perceptions of the three therapists' conditions and later levels of authenticity operates through the client's manner of engaging with felt experience. Together, these methods are designed to differentiate between temporal sequencing and process mechanisms, thereby providing a suitable probabilistic test of Rogers's hypothesis. However, while this design preserves temporal ordering and supports process-oriented analysis, it does not constitute a deterministic test of causality. Instead, it specifies the methodological conditions under which Rogers's hypothesis can be examined probabilistically, with empirical claims necessarily interpreted within the limits of longitudinal observational data.

Therefore, this examination is conducted within clearly defined methodological limits. The findings do not constitute a complete verification of Rogers's six necessary and sufficient hypotheses. Rather, they represent a theoretically principled and methodologically coherent test of a central relational pathway within the hypothesis, aligning temporal ordering, measurement, and theory within a single longitudinal framework. The contribution of the thesis, therefore, lies in clarifying which aspects of Rogers' hypothesis can be examined empirically, and under what conditions, rather than in establishing its universal validity. The findings provide a partial test of sufficiency, focused on associations between perceived therapist conditions and later levels of authenticity.

The following chapter builds on this methodological foundation by examining the internal structure of the B-LRI and the AS using principal component analysis. Establishing coherent item groupings at this stage ensures that subsequent longitudinal and mediational analyses rest on psychometrically and theoretically aligned constructs.

Chapter 5: Results: *Principal Component Analyses of the Barrett-Lennard Relationship Inventory and the Authenticity Scale in a Clinical Setting*

5.1 Introduction

This chapter highlights a gap in the literature concerning the factorial structure of the Barrett-Lennard Relationship Inventory (B-LRI; Barrett-Lennard, 1962) and Authenticity Scale (AS; Wood et al., 2008). Earlier research has produced inconsistent findings for both measures. Studies of the B-LRI have variously supported a four-factor model representing empathy, congruence, level of regard, and unconditionality (Barrett-Lennard, 1962, 1986, 2015), while others have reported fewer components or high intercorrelations among the subscales (Blatt et al., 1999; Blatt & Zuroff, 2005; Elkin et al., 1999). Similar instability has been observed in the AS, particularly in accepting external influences (Knoll et al., 2015; Lutz et al., 2021). These inconsistencies suggest that using subscales independently may not adequately capture clients' perceptions of the quality of the therapeutic relationship or their self-reported authenticity.

Accordingly, a principal component analysis was conducted to examine how items from the B-LRI and AS clusters within the Human Flourishing Project (HFP) sample cluster. This analysis aims to explore the latent structure underlying item responses in an adult clinical population receiving person-centred therapy (PCT) and to determine whether the measures are best represented as unified constructs or by distinct sub-dimensions in this context.

The conceptual foundation of this approach can be traced to Spearman's (1904) development of factor analysis, which sought to uncover the underlying dimensions accounting for observed correlations among variables. This early work laid the groundwork for modern structural equation modelling, providing the statistical rationale for examining empathy, congruence, unconditional positive regard and authenticity as interrelated components of Rogers's person-centred framework rather than as isolated variables. Within this quantitative framework, latent-variable modelling provides the broader conceptual framework for examining the measurement properties of these constructs.

This chapter is structured as a cross-sectional examination of the AS at Session 1 and the B-LRI at Session 5, to explore whether their item structures support latent representations that can later be integrated within a cohesive analytic framework. Modelling constructs at the latent level allows for more accurate estimation by correcting for measurement error (Kenny & Judd, 1984). In this context, exploratory factor analysis (EFA) is used as a preliminary step to examine how individual items load onto their underlying constructs before these representations are taken forward into subsequent analyses. Estimating constructs in this way, rather than relying solely on observed scores, reduces error variance and produces more reliable estimates of the relationships between variables.

5.1.1 Exploratory Factor Analysis Rationale

Understanding the nature of the HFP data is central to determining an appropriate analytic strategy. The B-LRI and the AS are composed of Likert-type response formats with different scale ranges and are therefore ordinal. Although the response options reflect ordered categories rather than equal intervals, such measures are commonly treated as approximately continuous in psychological

research when summed or averaged across items. Adopting this pragmatic assumption permits the use of Pearson correlations and factor analytic techniques, which form the basis of the analyses reported in this chapter.

While both exploratory and confirmatory factor analytic approaches can be applied to ordinal or continuous data using appropriate estimators, the decision to employ EFA in this study was driven by conceptual rather than measurement-level considerations. Although the B-LRI and AS have established validity and reliability in their factor structures, these structures were developed in different contexts and for different analytic purposes. The present thesis does not aim to confirm or replicate these predefined models.

Instead, this chapter focuses on how individual items from the B-LRI and AS behave within a session-based clinical dataset derived from routine therapeutic practice. The analytic emphasis is therefore placed on item-level functioning rather than on testing the fit of established subscale configurations. EFA was selected because it allows the latent structure of the data to emerge empirically, without imposing prior constraints on item–factor relationships. In contrast, confirmatory factor analysis would require the specification of a priori models that assume the stability and applicability of existing factor structures, which is not aligned with the exploratory aims of this chapter.

The use of EFA is further consistent with a pragmatic methodological stance adopted throughout the thesis. The principle of parsimony suggests favouring simpler explanatory concepts over more complex ones, assuming all other factors are equal. In this context, parsimony involves examining whether the observed data can be accounted for without imposing unnecessary structural assumptions. This stance prioritises empirical exploration within applied clinical settings and remains open to the possibility that measures may organise differently when administered across therapy sessions. Thus, using a

confirmatory factor analysis by confirming that items belong to distinct factors involves trading off alternative explanations at an early stage. The aim here is to capture the item structure of the B-LRI and AS by discovering which items belong to which factors, rather than assuming this structure in advance.

It is acknowledged that any factor analytic approach necessarily involves a degree of abstraction from lived experience. As Cooper (2020) notes, the use of numerical indicators in psychotherapy research risks oversimplifying complex and subjective human processes, particularly in the absence of a standardised unit of psychological measurement. In this sense, EFA is treated not as a definitive representation of client experience, but as a pragmatic tool for exploring item structure while remaining mindful of the limits of quantification.

The first part of the chapter focuses on the decision-making process leading to the implementation of an Exploratory Factor Analysis (EFA). Separate EFAs are conducted for the AS at Session 1 and for the B-LRI at Session 5 within the HFP database. The second part of the chapter reports the results for the B-LRI followed by the AS, using varimax rotation for factor extraction. Factor loadings were considered adequate if they exceeded 0.48 for the B-LRI (Cramer, 1986; Murphy, 2010) and 0.60 for the AS (Cartwright et al., 2020), using an orthogonal forced solution. The final sections of the chapter present the discussion and the limitations encountered during the analysis.

5.2 Method

5.2.2 Measures

The Barrett-Lennard Relationship Inventory (B-LRI; Barrett-Lennard, 1962) was used to assess clients' perceptions of the therapist's relational attitudes. The client-completed Other-to-Self version was administered at Session 5. The scale

comprises 40 items rated on a six-point Likert scale and is traditionally organised into four subscales: Empathy (E), Congruence (C), Unconditionality (U), and level of regard (LOR).

The Authenticity Scale (AS; Wood et al., 2008) was used to assess clients' self-reported authenticity and was administered at Session 1. The scale consists of 12 items rated on a seven-point Likert scale and is organised into three subscales: Self-Alienation, Accepting External Influence (AEI), and Authentic Living.

For both the B-LRI and the AS, initial factor analyses were conducted using items in their original wording, without reversing negatively worded items. This procedure was adopted to examine whether emergent factor structures reflected conceptual content or were influenced by item wording effects. Reverse-scored solutions were subsequently examined as supplementary analyses to assess the robustness of the factor structures.

5.2.2 Data Analysis for EFA

The handling of missing data differed across measures and, therefore, warrants critical reflection. For the B-LRI at Session 5, the original dataset comprised 210 clients. A predefined item-level missingness criterion was applied, excluding participants with more than 3 missing responses (approximately 5% of scale items). This resulted in a final sample of 194 participants, with those with 1 or 2 missing responses retained. Missing values were coded as 999 to distinguish them from valid responses during data handling. This approach was informed by the length of the B-LRI and the conceptual overlap across its items, meaning that limited missingness was unlikely to distort the underlying construct.

In contrast, a complete-case approach was adopted for the AS due to its short length. Of the original 336 clients, 26 were excluded because they exceeded the allowable level of missing data, resulting in a final sample of 310 participants. Given that the AS consists of only 12 items, each carries substantial conceptual weight, and partial scale completion could misrepresent authenticity.

These decisions reflect a trade-off between maximising sample retention and preserving construct integrity. While this strategy prioritised the validity and interpretability of scale scores, it introduced asymmetry in handling missing data and assumed that item-level missingness was random. Future research could explore alternative approaches, such as planned missing designs or scale-specific imputation methods, particularly for short theory-driven measures such as the AS.

Following data screening and missing-data decisions, preliminary analyses were conducted to assess the suitability of the retained datasets for EFA. Kaiser (1960) and Bartlett (1950) proposed preliminary diagnostics for evaluating factorability, including the Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy and Bartlett's Test of Sphericity. Kaiser (1960) introduced the KMO statistics to assess whether the degree of shared variance among variables is sufficient to support factor extraction; values closer to 1 indicate stronger intercorrelations and greater suitability for factor analysis. In contrast, low KMO values indicate that partial correlations dominate, suggesting that factor analysis is unlikely to yield meaningful components. Kaiser (1974) recommended a minimum KMO value of 0.50 for proceeding with factor analysis.

Bartlett (1950) developed the Test of Sphericity to examine whether the observed correlation matrix differs significantly from an identity matrix. A significant result indicates that the variables are sufficiently intercorrelated to

justify factor analysis. In this study, rejection of the null hypothesis ($p < .05$) confirmed that the correlation structure was appropriate for EFA, supporting the presence of meaningful relationships among variables.

Guadagnoli and Velicer (1988) argued that principal component analysis (PCA) is appropriate when the analytic aim is to identify dominant sources of variance rather than to estimate latent constructs. Accordingly, the EFA was conducted using principal component analysis with varimax rotation, as originally proposed by Kaiser (1958), to enhance interpretability by maximising the variance of factor loadings across components. Jolliffe (1972) suggested retaining components with eigenvalues greater than 1, as these account for a substantial proportion of variance in the data. In addition, the scree plot, introduced by Cattell (1966), was examined to identify the point at which additional components contributed minimal explanatory value.

Given the modest sample size for the B-LRI, both parallel analysis and the scree plot were used to inform factor retention decisions, thereby strengthening the robustness of the analytic strategy. Horn (1965) originally proposed parallel analysis as a method for determining the number of factors to retain by comparing eigenvalues derived from the observed data with those generated from random datasets of equivalent structure. Subsequent work by Zwick and Velicer (1986) and Velicer et al. (2000) demonstrated the superiority of parallel analysis over eigenvalue-based rules. More recently, Cooper (2020) strongly recommended a multi-method approach to factor retention, particularly when sample sizes are modest or factor structures are complex (see also Cosemans et al., 2022). In the present study, factors were retained only when observed eigenvalues exceeded their random counterparts, indicating meaningful variance beyond chance.

5.3. Results: Barrett-Lennard Relational Inventory

Data from 194 clients were used to run a principal components analysis on the items of the B-LRI: empathy (E), unconditionality (U), congruence (C), and level of regard (LOR). The principal component factor analysis using the varimax method of extraction yielded 10 factors, each with an Eigenvalue of 1 or greater and items loading over 0.48. The most significant component accounted for 63.457% of the total variance explained. A three-factor solution was revealed.

Table 5.1 shows that the KMO test yielded a value of 0.86, indicating that the HFP has a "good" degree of sampling adequacy (see Hutcheson & Sofroniou, 1999, Pp 224-225). Bartlett's Test of Sphericity yielded a p-value of .00, indicating statistical significance. This implies that the correlations among the variables in the dataset are significantly different from zero. The results of the preliminary test, as indicated by the KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity, showed meaningful relationships among the variables, reinforcing the appropriateness of applying EFA on the HFP sample size.

Table 5.1: KMO & Bartlett's test for B-LRI in HFP sample

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.86
Bartlett's Test of Sphericity	Approx. Chi-Square	2969.84
	Df	780
	Sig.	.000

Note. N= 194; B-LRI; Barrett-Lennard Relational Inventory

An initial principal component analysis with varimax rotation identified 10 components with eigenvalues greater than 1.00. When factor loadings below .48 were suppressed (Cramer, 1986), 34 of the 40 items loaded meaningfully on at least one component. Six items (Items 4, 9, 12, 15, 30, and 36) failed to load above the .48 criterion and were excluded from further interpretation. These items were distributed across the C, E, U, and LOR subscales.

Inspection of the initial solution indicated that several components contained mixtures of items from different original subscales, with some components dominated by reverse-worded items.

Factor 1 was the most substantial, comprising nine items and accounting for 26.7% of the variance. These items were drawn mainly from U, with additional contributions from LOR and C subscales, indicating overlap across relational domains rather than alignment with a single original subscale. Subsequent components were smaller and less coherent. Factor 2 comprised six items and accounted for 8.45% of the variance, combining items from E, LOR, and U subscales. Factor 3 contained three positively worded LOR items and accounted for 5.40% of the variance, although only a subset of items from this subscale clustered together.

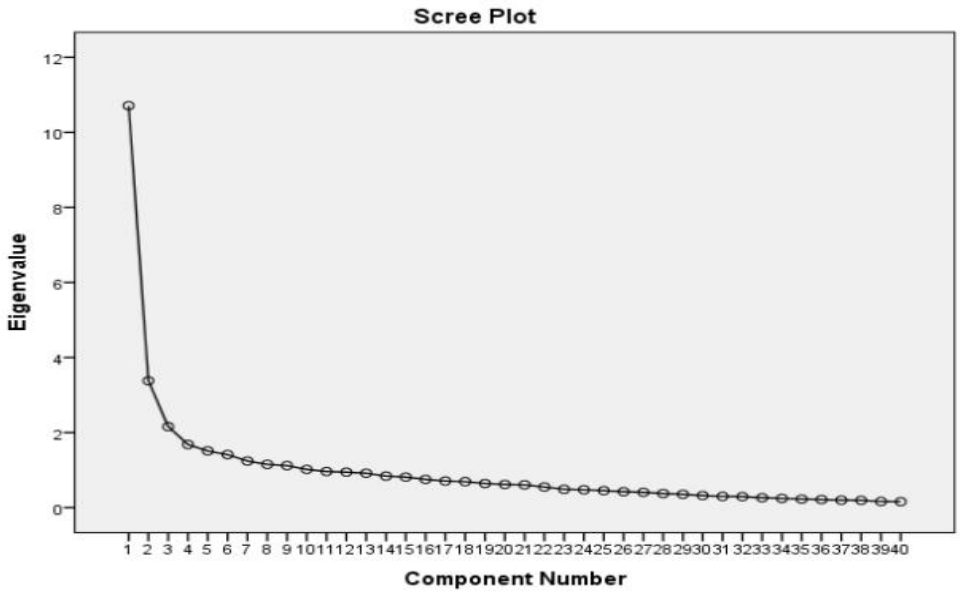
Factor 4 comprised four C items and accounted for 4.21% of the variance, while Factor 5 consisted of 3 items of the E subscale (3.78% of the variance), most of which were negatively worded. Factor 6 contained 3 items drawn from E and U subscales (3.10% of the variance), and the Factor 7 comprised two U items (2.88% of the variance).

As factors beyond the seventh component did not yield interpretable or theoretically coherent groupings, further criteria were applied to determine the most appropriate factor solution.

5.3.1 Factor Extraction

Figure 5.1 presents the scree plot for the B-LRI-OS 40, with eigenvalues plotted on the y-axis and the extracted components on the x-axis.

Figure 5.1: Scree plot of the underlying factor of the B-LRI-OS 40



Applying the eigenvalue-greater-than-one criterion (Kaiser, 1958) initially identified a ten-factor solution. However, given this criterion's tendency to overestimate the number of factors, particularly in inventories with many items, additional criteria were applied to yield a more parsimonious and interpretable solution. Visual inspection of the scree plot indicated a clear point of inflexion after the third factor, suggesting a three-factor solution as the most appropriate cut-off (Cattell, 1966).

The eigenvalues of the first four factors were 10.71, 3.38, 2.16, and 1.68, accounting for 26.77%, 8.45%, 5.40%, and 4.21% of the variance, respectively. Although four factors exceeded the eigenvalue threshold of 1, the scree plot indicated diminishing explanatory value beyond the third factor. All items of the B-LRI loaded across four factors, with item loadings ranging from 0.48 to 0.76, indicating that a four-factor solution was statistically viable but potentially over-extracted.

To further inform factor retention, parallel analysis was conducted. Table 5.2 presents a portion of the parallel analysis results, comparing eigenvalues derived from the HFP sample with mean eigenvalues and 95% critical values obtained from randomly generated datasets of equivalent structure. Factors were retained only when the observed eigenvalue exceeded the corresponding critical value (Horn, 1965). The first three factors met this criterion, whereas the fourth factor did not, indicating that it did not explain variance beyond chance levels. This result provided additional support for retaining a three-factor solution.

Table 5.2: Parallel Analysis Table for B-LRI

Number of Items	Raw Data	Means	Critical Value (95% Confidence)
1	10.71	2.81	2.22
2	3.38	1.95	2.04
3	2.16	1.85	1.93
4	1.68	1.76	1.83
...	...	...	...
40	0.16	0.29	0.32

Note. n= 194; B-LRI; Barrett-Lennard Relational Inventory; Session 5

Three-Factor Solution

The three-factor solution accounted for 40.62% of the total variance in the data. Communalities were examined to assess how well the extracted factors accounted for variance at the item level. Prior to extraction, all items had communalities of 1.00, indicating that each item initially accounted for its full variance. In the unconstrained solution, all items demonstrated extraction communalities above 0.50, suggesting meaningful contributions to the common factor space. After imposing the three-factor solution, communalities ranged from 0.27 to 0.65. This reduction reflects the trade-off associated with enforcing a more parsimonious structure, whereby explanatory coverage is reduced in favour of interpretability and factor stability.

Appendix 10 presents two tables: Table 10. A presents the items in rank order along with their factor loadings on three different factor solutions (Factor 1, Factor 2, and Factor 3) derived using a varimax rotation. Only loadings exceeding the 0.48 criterion are reported. Of the 40 original items, 30 loaded meaningfully on at least one of the three retained factors. Table 10.B presents the remaining 10 items that failed to load significantly on any retained factor. Notably, half of these non-loading items belonged to the Empathy subscale, with four of the five being negatively worded. This pattern may indicate that certain empathy items, particularly negatively phrased statements, were less coherently represented within the imposed three-factor structure.

Factor 1 comprised 15 items with loadings above the 0.48 threshold and accounted for 26.7% of the variance. These items represented a blend of the original B-LRI subscales, including six U items, four C items, four LOR items, and one E item. Notably, all items loading on Factor 1 were negatively worded in the original scale. Given that 20 items in the B-LRI are negatively worded, the clustering of 15 such items on this factor suggests a strong influence of item

wording. The highest loading item on this factor was item 31 (“My therapist approves of some things about me … and plainly disapproves of other things”), with a loading of 0.80.

Factor 2 consisted of nine items and explained 8.4% of the variance. These items included four from the C items, four from the LOR items, and one from the E items. The item with the highest loading on this factor was item 21 (“My therapist cares for me”), with a loading of 0.74.

Factor 3 comprised six items and accounted for 5.4% of the variance. Three items originated from the E items, with the remaining items drawn from C, U, and LOR.

These findings suggest that the three-factor solution does not provide clear support for a theoretically distinct structure of the B-LRI. Although the solution accounted for a moderate proportion of the total variance, the pattern of item loadings indicates that the extracted factors are not organised around the factors. Instead, items from U, C, LOR, and E were distributed across all three factors, with no factor corresponding uniquely to a single relational construct.

The most salient feature of the three-factor solution was the concentration of negatively worded items on the first factor. Because these items were drawn from multiple subscales, their clustering suggests a wording-related method effect rather than a substantive psychological dimension. This interpretation is reinforced by the strongest loadings, which reflected evaluative or disapproving statements that cut across the intended conceptual distinctions of the scale.

To examine this possibility, a supplementary principal component analysis was conducted after reversing item scores. The resulting pattern closely mirrored the original analysis, with the same items continuing to cluster together and

showing similar communalities. This suggests that the observed structure was robust and not solely attributable to item direction.

However, imposing a three-factor model also produced a marked reduction in communalities, indicating that explanatory coverage at the item level was sacrificed in favour of a more parsimonious but less representative solution. In addition, 25 % of the items failed to load meaningfully on any factor, further weakening the stability and interpretability of the model.

5.4 Discussion

The present findings did not support the four-factor structure originally proposed for the B-LRI-OS when applied in a clinical context. Across multiple extraction strategies, including a forced three-factor solution, the resulting factors failed to align with the E, U, C, and LOR subscales specified by Barrett-Lennard. This pattern is consistent with earlier findings reported by Murphy (2010), suggesting that the theoretical sub-dimensions of the B-LRI may not be empirically separable in applied therapeutic settings.

The factor-analytic results indicate that clients may not differentiate between the relational sub-dimensions of the B-LRI as originally theorised. Rather than responding to items as discrete indicators of specific therapist conditions, clients appear to evaluate the therapeutic relationship as a unified relational experience. This interpretation is supported by the emergence of a dominant factor characterised by the clustering of negatively worded items across subscales. These items loaded strongly and in the expected direction, indicating that clients reliably detect relational deficits, but do so at the level of overall relational quality rather than through differentiation between specific therapist conditions.

It is important to clarify that these findings relate specifically to the client-completed Other-to-Self version of the B-LRI and should not be conflated with observer-rated versions of the instrument, such as the B-LRI-Obs. Observer measures are designed to differentiate therapist behaviours associated with empathy, congruence, and unconditional positive regard, and observers may therefore be better positioned to distinguish among these conditions. Consistent with this distinction, Bhatti et al. (2023) replicated the four-factor structure using observer ratings with younger clients receiving person-centred therapy. The absence of a clear subscale structure in the present analysis, therefore, does not suggest that the therapist's conditions are indistinguishable in practice, but rather that clients may not experience or report these conditions as separable dimensions.

From the client perspective, this pattern suggests that responses reflect an evaluation of the therapeutic relationship as a global relational climate rather than as a set of discrete therapist conditions. Attempts to impose a differentiated factor structure resulted in reduced communalities and a substantial loss of explained variance, indicating diminished explanatory power. This trade-off suggests that subdividing the B-LRI may compromise its ability to accurately represent the client's relational experience. Consequently, the use of individual subscales appears to be of limited value when assessing the therapeutic relationship from the client's phenomenological perspective.

These findings support the use of the total client B-LRI score as a more valid and interpretable representation of the therapeutic relationship. This conclusion is theoretically consistent with Rogers' position that the therapist's conditions operate as an integrated relational whole rather than as independent mechanisms. Empathy, congruence, and unconditional positive regard are

proposed as interdependent qualities that collectively shape the therapeutic climate, rather than as experiences that clients readily distinguish.

On this basis, the decision to model the therapeutic relationship as a single construct in the subsequent longitudinal analyses was both empirically and theoretically justified. Treating the B-LRI as a unified predictor in the Sequential Equation Modelling and mediation models aligns with the observed factor structure and preserves fidelity to the client's phenomenological experience. Modelling the subscales separately would have imposed a level of differentiation not supported by the data and risked misrepresenting the relational process under investigation.

This integrated interpretation also provides a strong rationale for the development and use of shorter, global measures such as the mini-B-LRI proposed by Chen et al. (2021). By abandoning attempts to psychometrically separate the therapist's conditions, the mini-B-LRI captures the client's overall perception of the relational climate. In this sense, the use of a global score does not represent theoretical simplification, but a refinement of measurement that more closely aligns with how the therapeutic relationship is experienced and reported by clients.

5.5 Results: Authenticity Scale

Data from 336 clients were used to analyse the items of the authenticity scale, namely self-alienation, authentic living, and accepting external influence. The principal component factor analysis using the varimax method of extraction showed a three-factor solution with eigenvalues equal to or greater than one. The most significant component accounted for 68.41% of the total variance explained.

Table 5.5 shows that the KMO test reported a value of 0.8, which indicates that the dataset shows favourable conditions for uncovering latent factors or underlying patterns, and a Bartlett's Test of Sphericity that obtained a p-value of .000 showing statistical significance. The results of the factor analysis, as showed by the KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity, showed meaningful relationships among the variables, reinforcing the appropriateness of applying factor analysis to the data.

Table 5.3: KMO and Bartlett's Test for the AS

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.8
Bartlett's Test of Sphericity	Approx. Chi-Square	1819.20
	Df	66
	Sig.	.000

Note. n= 336; AS; Authenticity Scale; Session 1

Factor Extraction

Inspection of the scree plot indicated a clear three-factor solution, with a marked inflection after the third component (see Figure 5.2). The eigenvalues of the first three factors were 4.01, 2.47, and 1.73, accounting for 33.44%, 20.54%, and 14.43% of the variance, respectively. All items loaded strongly on one of the three factors, with loadings ranging from 0.62 to 0.86. Results suggest that three factors generate the assessments of authenticity. To confirm the result of the scree plot, a parallel analysis was carried out.

Figure 5.2: Scree Plot of the Underlying Factor of the Authenticity Scale

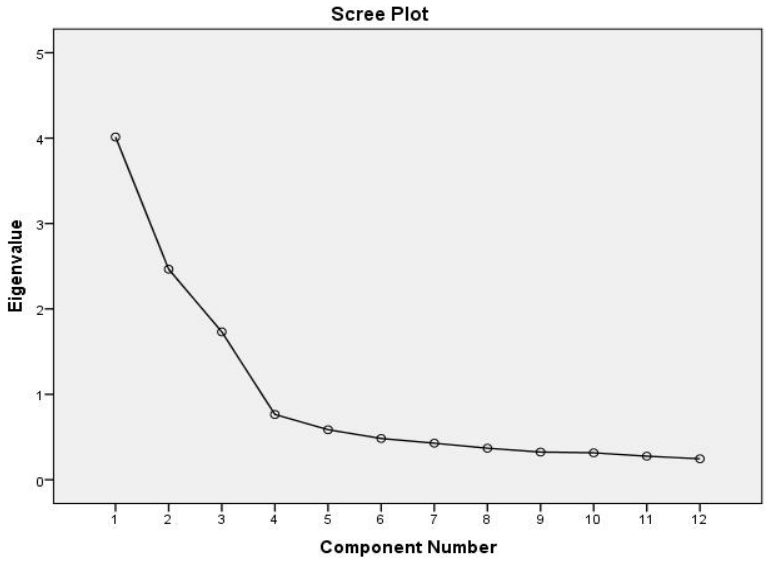


Table 5.4 presents the results from the parallel analysis. It shows that the point where the critical value exceeds the eigenvalue of the raw data is at 3. This confirms the result of the scree plot that a three-factor solution is justified.

Table 5.4: Parallel Analysis Table for AS at Session 1

Number of Items	Raw Data	Means	Critical Value (95% Confidence)
1	4.01	1.32	1.4
2	2.47	1.24	1.3
3	1.73	1.17	1.22
4	0.76	1.11	1.15
...	...	...	...
12	0.25	0.71	0.76

Note. n= 336; *AS*=Authenticity Scale at Session 1

Three Factor Solutions

When a three-factor solution was imposed, the total variance explained remained unchanged at 68%, and the communalities and factor loadings were consistent with those of the unconstrained solution. No items exhibited substantial cross-loadings, indicating good discriminant validity. All items loaded in the expected direction, with no negative loadings observed. Table 5.5 shows no negative loadings, which indicates that the items loaded in the intended direction. The factor structure closely replicated the original subscales of the AS.

Factor 1 comprised four items (Items 10, 12, 2, and 7) and accounted for 33.44% of the variance. These items correspond to the self-alienation subscale and capture individuals' sense of disconnection from, and limited access to, their inner experiences.

Factor 2 included four items (Items 6, 4, 3, and 5) and explained 20.54% of the total variance, reflecting the accepting external influence subscale and indicating the extent to which individuals are guided by external expectations and opinions.

Factor 3 also consisted of four items (Items 9, 11, 8, and 1) and accounted for 14.46% of the variance. These items corresponded to the authentic living subscale and reflected individuals' awareness of and alignment with their core values.

Table 5.5: The AS Items Loading on Three-Factor Solutions.

	F1	*F2*	*F3*
Self-Alienation			
10. I feel out of touch with the "real me"	0.84		
12. I feel self-alienated from myself	0.83		
2. I don't know how I really feel inside	0.81		
7. I feel as if I don't know myself really well	0.81		
Accepting External Influence			
6. Other people influence me greatly		0.86	
4. I usually do what people tell me to do		0.83	
3. I am strongly influenced by the opinions of others		0.80	
5. I always feel I need to do what people expect me to do		0.75	
Authentic Living			
9. I am true to myself in most situations			0.86
11. I live in accordance with my values and beliefs			0.84
8. I always stand by what I believe in			0.83
1. I think it is better to be yourself than to be popular			0.62

5.6 Discussion

The findings of the present study provide strong support for the structural integrity of the AS when applied in a clinical context. Principal component analysis replicated the original three-factor structure: self-alienation, accepting external influence, and authentic living—with all items loading cleanly onto their intended factors. The stability of this structure, alongside strong factor loadings and favourable sampling adequacy, suggests that the AS functions as a

psychometrically coherent measure within the HFP sample. In this sense, the scale demonstrates clear measurement validity and can be considered suitable for assessing authenticity-related outcomes in therapy research.

Within this structure, self-alienation emerged as the most influential dimension, accounting for the largest proportion of explained variance. This finding suggests that experiences of disconnection from one's felt self may play a particularly salient role in how clients construe authenticity in therapeutic contexts. Such a pattern is theoretically consistent with person-centred accounts, which position incongruence and alienation as central markers of maladjustment and as key targets of therapeutic change.

Contrary to concerns raised by Cartwright et al. (2020) and Toper et al. (2020) regarding the instability of the authentic living subscale, the present findings showed strong loadings for authentic living items, with most exceeding .80. This indicates that, at least in the present clinical sample, authentic living functions as a coherent dimension rather than a weak or unstable subcomponent. The factor-analytic results suggest that all three subdimensions of the AS capture their intended constructs consistently and interpretably.

However, strong psychometric performance does not necessarily imply theoretical sufficiency. As Cattell (1978) cautioned, scales composed of highly similar items may exhibit *bloated specific factors*, in which elevated loadings and internal consistency reflect redundancy rather than meaningful conceptual differentiation. Cooper (2020) similarly observed that very high reliability coefficients can obscure limited construct breadth, particularly when items are closely paraphrased. In the present analysis, the consistently high loadings across the AS factors suggest substantial conceptual overlaps, indicating that the scale

functions primarily as an index of a unified experiential construct rather than as a set of clearly differentiated dimensions.

This pattern does not call the validity of the AS into question, but it does constrain the interpretability of its subscale. Authenticity, within a Rogerian framework, is not conceptualised as a collection of discrete traits but as an integrated process reflecting the client's relationship to inner experience and sources of evaluation. Accordingly, the global AS score provides a more theoretically coherent and psychometrically stable indicator of movement away from alienation and toward congruence. Treating authenticity as a unified outcome allows the scale to capture the cumulative impact of the therapeutic relationship over time, without over-interpreting narrower components whose independence and stability remain uncertain.

Furthermore, broader limitations inherent to self-report measures must be acknowledged. As Edwards (1959) and Paulhus (1984, 2002) observed, social desirability, self-deceptive enhancement, and impression management can influence how individuals respond to items assessing self-related constructs (See also Hamlin et al. 2022). These factors may further contribute to item overlap and inflated associations within the AS. Future research would benefit from incorporating measures of social desirability or complementary observer-based indices of authenticity to strengthen construct validity.

5.7 Conclusion

In conclusion, the EFA of the B-LRI and the AS provide a coherent foundation for constructing continuous variables suitable for longitudinal modelling. The component analysis of the B-LRI did not naturally decompose into a four-factor solution. The scale appears to function as a global measure of clients' overall perception of the therapist's conditions, with strong

interdependence among its components and sensitivity to item wording. This finding is theoretically consistent with Rogers' proposition that the client's perception of the three therapists' conditions functions as an integrated relational climate rather than as separable dimensions.

In contrast, the component analysis of the AS yielded a three-factor solution; however, evidence of bloated specific factors suggested substantial conceptual overlap among items. Within a Rogerian framework, constructive personality change is understood as arising from the relational context rather than from isolated intrapersonal traits. Consequently, the AS appears to function more effectively as an indicator of a unified authenticity construct than as a set of independent subcomponents. Neither the Authentic Living subscale nor the reverse-scored Accepting External Influence subscale and Self-alienation subscale alone adequately captures movement toward authenticity. The overall AS score, therefore, provides a more stable and theoretically coherent indicator of authenticity as an integrated experiential outcome and was retained for subsequent analyses.

Accordingly, descriptive statistics and multiple bivariate correlations were conducted in SPSS using total scores, without categorical variables, to examine the relationship between B-LRI and authenticity. Mean scores were computed for composite session forms of the B-LRI (6-point Likert scale) and the AS (7-point Likert scale). Items were transformed as required (e.g., reverse scoring) and renamed accordingly (e.g., BLRI9R, AS2R). Composite total scores were then calculated for sessions 5, 10, 15, and 20 (e.g., SumBLRIS5, SumASS10) and used in subsequent analyses.

However, limitations are not limited to sample size alone (MacCalum et al. 1999). The feasibility of SEM is also constrained by measurement complexity, particularly when modelling the full B-LRI with multiple continuous indicators.

Although the use of total scores is appropriate and theoretically justified for regression-based analyses, this approach poses challenges for subsequent SEM analyses. Specifying all 40 B-LRI items as indicators of a single latent factor substantially increases the number of free parameters. In small samples, this level of model complexity risks non-convergence, under-identification, and unstable parameter estimates. Consequently, while total scores are retained for regression and pilot analyses, alternative modelling strategies are required when extending the analysis to SEM. The following chapter, therefore, presents a pilot study to evaluate whether the B-LRI and AS can be meaningfully integrated within an SEM across four therapeutic time points.

Chapter 6: Pilot Study: *Assessing the Feasibility of Longitudinal Modelling of Rogers' Six Necessary and Sufficient Conditions*

6.1 Introduction

This chapter examines whether the secondary dataset is suitable for modelling a temporal structure in which early perceptions of the three therapist conditions form a foundational pathway for later levels of authenticity across four therapy sessions. Rather than testing a full longitudinal model at this stage, the purpose of these preliminary analyses is to determine whether the data exhibit sufficient temporal coherence to justify more complex modelling in subsequent chapters.

Evaluating temporal structure requires careful attention to how associations unfold across time. Kenny (1975) highlighted the use of cross-lagged correlations (CLC) as an initial step in examining potential directional relationships between variables. CLC compares the association between each pair of variables across time points and can indicate "inferential correlation" and whether temporal ordering is plausible. Rogosa (1980), however, cautioned against interpreting CLC as evidence of causality. He argued that regression analysis provides a more transparent basis for assessing temporal ordering. Together, these positions suggest that the feasibility of a four-wave cross-lagged panel design (CLPD) depends not only on the presence of temporal associations but also on whether the dataset can support autoregressive and directional paths within a small sample.

This chapter draws on a purposive subsample of the HFP dataset, selected to examine the directional pathway implied by Rogers' six necessary and sufficient conditions. From the range of instruments routinely used within the HFP, the Barrett-Lennard Relationship Inventory (B-LRI) and the Authenticity Scale (AS) were selected as the primary relational and outcome measures, respectively.

To address this objective, a series of multiple regression analyses were conducted to examine whether the data exhibited a meaningful temporal structure. The present pilot study was designed to assess the temporal ordering across Sessions 5, 10, 15, and 20. Three regression models were specified to reflect the progression of therapy over time:

i. **Session 5 to Session 10 (Early-Mid Phase):** Clients' perceptions of the three therapist conditions at Session 5 will be associated with their later level of authenticity at Session 10, after accounting for authenticity at Session 5 and B-LRI at Session 10.
ii. **Session 10 to Session 15 (Mid-Late Phase):** Clients' perceptions of the three therapist conditions at Session 10 will be associated with their later level of authenticity at Session 15, after accounting for authenticity at Session 10 and B-LRI at Session 15.
iii. **Session 15 to Session 20 (Termination Phase):** Clients' perceptions of the three therapist conditions at Session 15 will be associated with their later level of authenticity at Session 20, after accounting for authenticity at Session 15 and B-LRI at Session 20.

These hypotheses assume that the facilitative conditions perceived earlier in therapy necessarily and sufficiently contribute to later levels of authenticity across time.

This chapter begins by describing the Human Flourishing Project (HFP) research design and identifying 59 clients who met the initial inclusion criteria. Preliminary regression analyses were conducted on this sample to evaluate the temporal plausibility of the relationship between clients' perceptions of the therapist's conditions and later authenticity. As these models did not yield sufficiently stable or interpretable inferential patterns, subsequent analyses were conducted on a more restricted subset of clients (N = 40) who met stricter inclusion criteria. This refinement resulted in clearer and more reliable temporal associations. Across both sets of analyses, early authenticity consistently emerged as a strong predictor of later authenticity, indicating substantial temporal stability.

Building on these findings, the chapter then introduces a structural equation modelling approach that incorporates autoregressive coefficients to account for this stability and to examine temporal relationships across four therapy sessions (Sessions 5, 10, 15, and 20). Due to non-convergence of the initial four-wave model, the analysis was further refined by removing non-salient time points and retaining Sessions 5 and 15 as the most theoretically and empirically informative measurement occasions for testing temporal ordering. Together, these analyses establish the empirical basis for selecting both the analytic sample and the key time points from the HFP design, providing the methodological foundation for the cross-lagged panel design and mediation analyses presented in the subsequent chapters.

6.2 Methods

Client inclusion criteria were defined to maintain synchronisation and stationarity across measurement occasions. Only clients who completed the initial 20-session block of weekly therapy, delivered over a minimum of 20 weeks,

were included. This procedure ensured full alignment of repeated measures across the defined time horizon, with no dropout within the analytic subsample. Therapist inclusion varied across assessment points according to client–therapist pairings. The final analytic sample comprised 59 clients and 28 therapists who met the criteria required for cross-lagged panel analysis.

Measures

At Sessions 5, 10, 15, and 20, clients completed B-LRI and the AS at the same time point. These measures were administered concurrently to assess clients' perceptions of the three therapist conditions and their level of authenticity within the same phase of therapy. Following the EFA reported in Chapter 5, global (total) scores of both the B-LRI and AS were used in all analyses.

Accordingly, associations between clients' perceptions of the three therapist conditions and their levels of authenticity are understood as reflecting the degree of alignment between lived experience and self-concept at a given session. Convergence between these measures indicates that clients who perceive higher levels of empathy, congruence, unconditionality, and level of regard also report greater alignment between their self-concept and organismic experience, alongside a reduction in self-alienation and conditions of worth. Such patterns are indicative of a more facilitative therapeutic process and a good outcome process, in which clients are able to perceive the therapist's relational stance and move toward higher levels of authenticity. Conversely, persistently low authenticity scores may indicate a poorer outcome, insofar as the three therapist conditions may not have been perceived by the client as sufficiently supportive of movement toward greater alignment.

Table 6.1 Demographics for Pilot Study

	Clients (N=59)	Therapist (N= 28)	Clients Concern	%
Gender				
Female	39 (66.10%)	22 (78%)	Depression and anxiety	15 (25.42%)
Male	18 (30.51%)	6 (22 %)	Trauma	11 (18.64%)
Non-Binary	1 (1.69%)	0 (0%)	Depression	7 (11.86%
Trans Man	1 (1.69%)	0 (0%)	Suicidal idealisation	6 (10.17%)
Age (Mean/SD)	37(12.0)	N/A	Anxiety	5 (8.47%)
Ethnicity			Addiction	3 (5.08%)
White British	48 (81%)	13 (50%)	Self-esteem	3 (5.08%)
Asian	2 (3.4%)	6 (22%)	Trauma and Depression	2 (3.39%)
Black Caribbean	3 (5.1%)	1 (4%)	Anxiety and Trauma	2 (3.39%)
Mixed British German	1 (1.7%)	0	Anxiety, Trauma and Depression	2 (3.39%)
Mixed Irish Colombian	1 (1.7%)	0	Eating disorder	1 (1.69%)
White European	1 (1.7%)	3 (12%)	NA	2 (3.39%)
N/A	3(5.08%)	3 (12%)		
Duration in *months* (Mean/SD)	10.26 (3.56)	N/A		
Client-therapist Match				
1	1(24%)	14 (50%)		
2	2(14%)	4 (14%)		
3	3(30%)	6 (21%)		
4	4(14%)	2 (7%)		
5	5(8%)	1 (4 %)		
6	6(10%)	1 (4%)		

Notes. n=59; *SD=* Standard Deviation

As shown in Table 6.1, the subsample reflects an adult population accessing person-centred counselling within a routine UK clinical context. The client group was predominantly female (39 women; 66.1%, 18 men; 30.5%) and largely White British. The most frequently reported presenting concerns were depression, anxiety, and trauma, with many clients reporting more than one area of psychological difficulty.

The therapist sample was also predominantly female (22 women; 78%, 6 men; 22%), with around half identifying as White British. Clinical exposure varied across therapists, with most working with a small number of clients and a smaller group working with multiple clients. As a result, client–therapist pairings were unevenly distributed, with one therapist working with up to six clients through to the termination phase.

Moreover, Table 6.2 shows that therapy termination occurred across a range of session numbers, from 20 to 40 sessions, indicating variability in treatment duration. This variation makes it difficult to define uniform early, middle, and late phases of therapy, as for clients who continued into longer treatment, session 20 may have represented a mid-point rather than an endpoint. However, two modal endpoints were evident at 20 and 40 sessions, where the largest proportions of clients ended therapy. The number of clients continuing beyond 20 sessions suggests that many either experienced ongoing therapeutic needs or perceived sufficient value in continuing the work. Equally, longer treatment duration may reflect variability in the extent to which trainee therapists were able to offer the three therapist conditions consistently across clients. However, the specific reasons for continuation or termination cannot be determined from the present data.

Table 6.2: Distribution of therapy sessions before ending Therapy

Clients (N=)	Frequency	Percentage
20	15	25.42%
21	1	1.69%
22	3	5.08%
23	2	3.39%
24	2	3.39%
25	4	6.78%
26	1	1.69%
27	2	3.39%
28	5	8.47%
29	3	5.08%
30	1	1.69%
32	1	1.69%
33	1	1.69%
34	1	1.69%
35	1	1.69%
37	2	3.39%
38	1	1.69%
40	13	22.03%

Note. This table presents the distribution of the total number of therapy sessions completed by 59 clients before the end of therapy. Frequencies and percentages reflect the number of clients completing therapy at each session beyond 20 sessions.

6.3 Results

Table 6.3 presents the descriptive statistics for authenticity (AS) and client-perceived therapist conditions (B-LRI) across Sessions 1, 5, 10, 15, and 20. Cronbach's alpha values ranged from .82 to .94 for both measures across sessions, indicating good to excellent internal consistency. Overall, the descriptive statistics show systematic change over time in both authenticity and clients' perceptions of the therapist's conditions.

Table 6.3 Means and Descriptive Statistics

	N	Mean	SD	α
AS S1	59	48.31	12.43	0.84
B-LRI S5	59	64.76	24.99	0.89
AS S5	59	47.8	13.53	0.87
B-LRI S10	59	71.51	30.6	0.94
AS S10	59	52.66	11.86	0.82
B-LRI S15	59	71.19	26.34	0.93
AS S15	59	52.94	12.59	0.86
B-LRI S20	59	76.61	24.31	0.87
AS S20	59	53.8	14.17	0.93

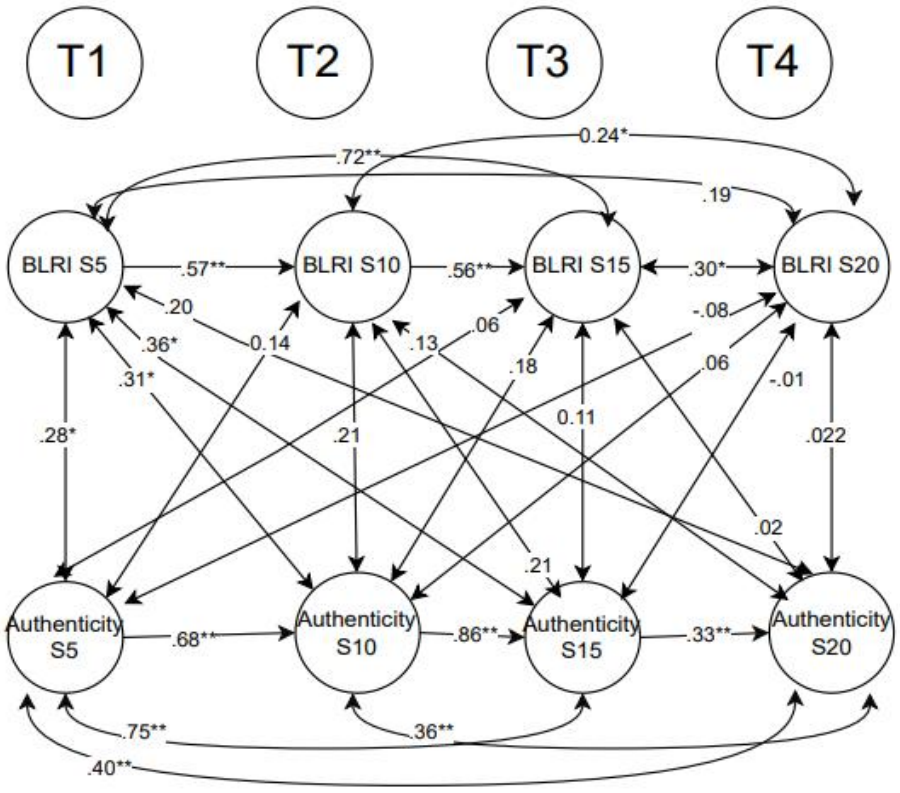
Note. n=59; AS= Authenticity Scale, B-LRI= Barret-Lennard Relational Inventory; S5= Session 5, S10= Session 10, S15= Session 15, S20= Session 20; SD= Standard Deviation

Mean authenticity scores show an overall increase across therapy. Scores were similar at Session 1 (M = 48.31, SD = 12.43) and Session 5 (M = 47.80, SD = 13.53), followed by a more marked increase at Session 10 (M = 52.66, SD = 11.86). Authenticity levels then remained broadly stable at Session 15 (M = 52.94, SD = 12.59) and increased slightly by Session 20 (M = 53.80, SD = 14.17). This pattern indicates that higher levels of authenticity were most evident during the early to mid-phases of therapy, with smaller changes observed thereafter. Client-perceived therapist conditions (B-LRI) also showed an overall increase across sessions. Mean scores rose from Session 5 (M = 64.76, SD = 24.99) to Session 10 (M = 71.51, SD = 30.60), remained similar at Session 15 (M = 71.19, SD = 26.34), and increased further by Session 20 (M = 76.61, SD = 24.31).

Figure 6.1 presents the CLC structure between B-LRI and AS across Sessions 5, 10, 15, and 20. The figure displays both autoregressive and cross-lagged associations, allowing the temporal direction and relative strength of

relationships between client-perceived therapist conditions and authenticity to be examined across time.

Figure 6.1: Cross-lagged Correlation Between B-LRI and AS Across Four Time Points



Note. n=59; *Authenticity*= Authentic Scale, *B-LRI*= Barret Lennard Relational Inventory, Scale; *S5*= Session 5, *S10*= Session 10, *S15*= Session 15, *S20*= Session 20

The CLC shows strong stability over time within both constructs across different sessions. Earlier B-LRI scores are moderately to strongly correlated with scores in later Sessions, and authenticity also displays consistent stability over time. However, the cross-lagged relationships between B-LRI and authenticity are weaker, and their timing varies. Notably, associations with subsequent

authenticity appear for B-LRI at Session 5, but B-LRI at later sessions does not consistently relate to authenticity. The most significant cross-lagged relationship is between B-LRI at Session 5 and authenticity at Session 15 ($r = .36$, $p < .05$). There is evidence of earlier B-LRI associating with later authenticity, but not vice versa. These findings suggest no reciprocal influence over time, revealing an asymmetric temporal pattern where earlier client-perceived therapist conditions more reliably relate to later authenticity than the reverse. Therefore, the CLC did not indicate consistent inferential associations between B-LRI and authenticity across all time points.

As CLC alone are limited in their ability to establish temporal ordering (Rogosa, 1980), the relationship was examined further using multiple regression analyses, which allow prior levels of authenticity and later B-LRI scores to be controlled when assessing temporal precedence.

Tables 6.4–6.6 trace the predictive contribution of clients' perceptions of the therapist's conditions across early, mid, and late phases of therapy, while controlling for prior levels of authenticity and concurrent therapist conditions at each stage. Each table presents the results of multiple regression analyses, including unstandardised coefficients (B), standardised coefficients (β), standard errors (SE), t-values, 95% confidence intervals (CI), and explained variance (R^2), allowing changes in predictive strength across phases to be examined.

Table 6.4 Early-Mid Phase B-LRI Predicting Authenticity at Session 10 (N=59)

Model		Unstandardised coefficients		Standardised coefficients		95% CI for β		
		B	SE	β	t	Lower	Upper	R^2
1	(Constant)	43.3	4.15	0	0	-0.25	0.25	
	B-LRI S5	0.15	0.06	.31b	2.43	0.05	0.56	.09a
2	(constant)	21.1	4.82	0	0	-0.19	0.19	
	B-LRI S5	0.04	0.06	0.09	0.7	-0.16	0.33	
	AS S5	0.57	0.09	.65b	6.39	0.44	0.85	.48b
	B-LRI S10	0.03	0.05	0.07	0.55	-0.17	0.3	

Note. n=59; *AS=* Authenticity Scale, *B-LRI=* Barret-Lennard Relational Inventory; *S5=* Session 5; *S10=* Session 10; *SE=* Standard error, *CI=* Confidence Interval; *ap*< 0.05, *bp*<0.01

The early–mid phase regression in Table 6.4 shows that, in Model 1, higher client perceptions of the three therapist conditions at Session 5 predict higher levels of authenticity at Session 10 when entered alone ($\beta = .31$, $p < .01$), accounting for 9% of the variance, $F(1,57) = 5.91$, $p < .05$.

When baseline authenticity at Session 5 and concurrent therapist conditions at Session 10 are added in Model 2, the predictive effect of B-LRI at Session 5 is substantially reduced and no longer significant ($\beta = .09$). In contrast, authenticity at Session 5 emerges as a strong predictor of authenticity at Session 10 ($\beta = .65$, $p < .01$), with the full model explaining a substantial proportion of variance ($R^2 = .48$), $F(3,55) = 16.96$, $p < .001$. The increase in explained variance from Model 1 to Model 2 is significant ($\Delta R^2 = .39$), $\Delta F(2,55) = 20.47$, $p < .001$. These findings indicate that although early client perceptions of the three therapist conditions are associated with later authenticity, this association is largely accounted for by clients' earlier levels of authenticity, which explain a

greater proportion of variance in subsequent outcomes during the early–mid phase of therapy.

In contrast to the early–mid phase, the mid–late regression in Table 6.5 shows that client perceptions of the three therapist conditions at Session 10 do not significantly predict authenticity at Session 15 when entered alone (β = .21), accounting for a small proportion of variance (R^2 = .04), F(1,57) = 2.61, p = .11. This indicates that in model 1 early perceptions of the three therapists' conditions do not independently account for later authenticity during mid-late phase.

Table 6.5: Mid-Late Phase B-LRI Predicting Authenticity at Session 15 (N = 59)

		Unstandardised coefficients		Standardised coefficients		95% CI for β		
Model		B	SE	β	t	Lower	Upper	R^2
1	(constant)	46.8	4.13	0	0	-0.26	0.26	
	B-LRI S10	0.08	0.07	0.21	1.61	-0.05	0.47	0.04
2	(constant)	4.4	4.54	0	0	-0.14	0.14	
	B-LRI S10	0.01	0.04	0	0.05	-0.17	0.18	
	AS S10	0.88	0.08	.82b	11.14	0.68	0.98	.71b
	B-LRI S15	0.03	0.04	0.06	0.71	-0.11	.24	

Note. n=59; *AS=* Authenticity Scale, *B-LRI=* Barret-Lennard Relational Inventory; *S10=* Session 10; *S15=* Session 15; *SE=* Standard error, *CI=* Confidence Interval; *ap*< 0.05, *bp*<0.01

When authenticity at Session 10 and therapist conditions at Session 15 are included in Model 2, authenticity at Session 10 emerges as the dominant predictor of authenticity at Session 15 (β = .82, p < .01). The full model explains a large proportion of variance in authenticity at Session 15 (R^2 = .71), F(3,55) = 44.97, p < .001, representing a substantial increase in explained variance relative

to Model 1 ($\Delta R^2 = .67$, $p < .01$), $\Delta F(2,55) = 63.30$, p= 5.44. Neither early-phase therapist conditions (Session 5) nor mid-phase therapist conditions (Session 10) contribute uniquely to authenticity at Session 15 once earlier authenticity is taken into account. These findings indicate strong temporal continuity in authenticity from early therapy (Session 5) through the mid–late phase (Session 15), alongside a reduced direct contribution of client-perceived therapist conditions beyond the early-mid phase of therapy.

Table 6.6: Termination-Phase B-LRI Predicting Authenticity at Session 20 (N = 59)

		Unstandardised coefficients		Standardised coefficients		95% CI for β		
Model		B	SE	β	t	Lower	Upper	R^2
1	(constant)	53.14	5.4	0	0	-0.26	0.26	
	B-LRI S15	0.01	0.07	0.02	0.13	-0.25	0.28	0
2	(constant)	19.06	9.38	0	-1.37	-0.24	0.23	
	B-LRI S15	-0.11	0.07	-0.17	0.05	-0.43	0.08	
	AS S15	0.96	0.14	.45b	6.86	0.21	0.7	.25b
	B-LRI S20	0.12	0.07	.31a	0.71	0.07	0.56	

Note. n=59; *AS*= Authenticity Scale, *B-LRI*= Barret-Lennard Relational Inventory; *S15*= Session 15; *S20*= Session 20; *SE*= Standard error, *CI*= Confidence Interval; *ap*< 0.05, *bp*<0.01

In the termination phase, Table 6.6 shows that B-LRI at Session 15 do not predict authenticity at Session 20 in Model 1 (β = .02), accounting for no meaningful variance F (1,57) = 0.02, p = .90. When authenticity at session 15 and the client's perception of the three therapist conditions at Session 20 are introduced, authenticity at Session 15 remains a significant predictor of later authenticity (β = .45, p < .01), explaining 25% of the variance. The R^2 Δ value of 0.25 in Table 6.6 indicates a significant improvement in explained variance between Model 1 and Model 2, $\Delta F(2,55) = 8.95$, $p < .05$. However, the client's

perception of the three therapists' conditions at Session 20 do not contribute uniquely once earlier authenticity is controlled. These findings indicate that, at termination, authenticity shows continuity from the preceding phase, while client perceptions of the therapeutic relationship are associated primarily with concurrent authenticity rather than predicting subsequent change.

In summary, Tables 6.4–6.6 reveal a clear temporal pattern in which authenticity shows strong continuity across therapy, while the predictive contribution of the client's perception of the three therapists' conditions is time-limited and developmentally specific. A delayed relational effect occurs only in the early-mid phase of therapy, where higher client perceptions of the three therapists' conditions at Session 5 are associated with higher levels of authenticity at Session 10. However, once clients' earlier levels of authenticity are considered, this early delayed effect is no longer unique. This indicates that early relational perceptions are connected to later levels of authenticity largely through clients' existing authentic functioning rather than operating as an independent influence. The results showed that earlier levels of authenticity mediate the relationship between earlier B-LRI scores and later levels of authenticity. In the mid–late and termination phases, therapist conditions do not predict later authenticity, and authenticity itself becomes the dominant predictor of subsequent authenticity. Although the clients' perception of the three therapists' conditions and authenticity remain positively aligned within the same session at termination, they do not explain additional variance beyond prior authenticity.

Consequently, analyses using the N = 59 sample did not meet the assumptions required for inferential longitudinal modelling. As outlined by Kenny (1975) and Rogosa (1980), CLPD require stable units of analysis and consistent measurement across time to support temporal ordering. In the present sample,

these assumptions were not fully met. The pattern did not demonstrate sufficient predictive strength across sessions to justify cross-lagged inference.

One plausible explanation for this pattern lies in the structure of the sample. While clients progressed through therapy in a broadly synchronised manner, therapist participation was uneven across sessions. As shown in Table 7.1, Therapists differed considerably in both the number of clients they served and the consistency with which they provided data. The exclusion of 19 cases in subsequent analysis due to missing audio recordings suggests that some therapists did not consistently record or submit session materials, causing gaps in the longitudinal data structure.

That is because when client–therapist dyads cannot be treated as stable units over time, associations observed across sessions may reflect variability in data availability rather than genuine temporal change, thereby violating the assumptions for inferential cross-lagged modelling (Kenny, 1975; Rogosa, 1980).

Restricting subsequent analyses to the n= 40 subsamples addressed these limitations by retaining only cases with consistent client and therapist participation across sessions. In this subsample, dyads progressed through the research protocol synchronously, restoring a more stable longitudinal structure. This provided a more appropriate basis for re-examining temporal ordering and for testing whether predictive relationships across sessions emerge when assumptions of synchrony and consistency are more fully met.

6.3.1 Validation with Different Sample Sizes

Table 6.7 compares the means and standard deviations (SD) for authenticity (AS) and client-perceived therapist conditions (B-LRI) across sessions in both the refined (n= 40) and full (n= 59) samples. Overall, the two samples display very similar average levels and variability at all time points. For

authenticity, both samples follow the same pattern, with lower mean levels at Session 5 and higher, relatively stable levels from Session 10 onwards. Mean AS scores were consistently slightly higher in the larger sample; however, all differences remained within one SD, indicating comparable distributions across samples**.**

Table 6.7 Client-Perceived Therapist Conditions and Authenticity Across Sessions and Samples

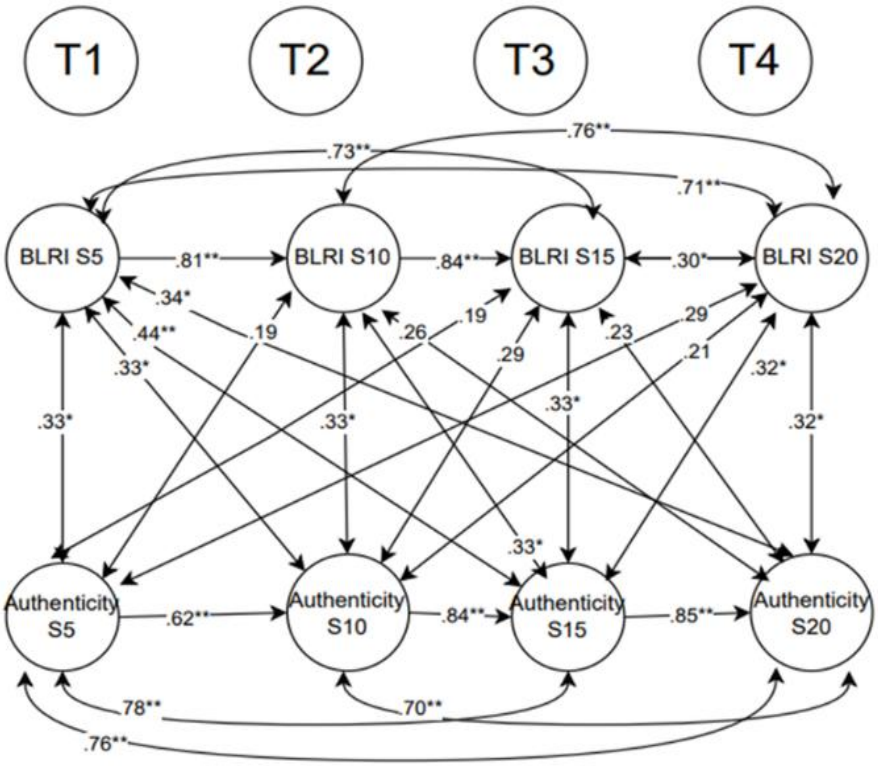
	N=	Mean	SD	N=	Mean	SD
B-LRI S5	40	64.18	26.02	59	64.76	24.99
AS S5	40	44.65	11.89	59	47.8	13.53
B-LRI S10	40	74.15	26.78	59	71.51	30.6
AS S10	40	50.75	12.47	59	52.66	11.86
B-LRI S15	40	75.82	28.79	59	71.19	26.34
AS S15	40	51.15	12.87	59	52.94	12.59
B-LRI S20	40	78.6	25.35	59	76.61	24.31
AS S20	40	51.05	14.42	59	53.8	14.17

Note. n=59 and n= 40; AS= Authenticity Scale, B-LRI= Barret-Lennard Relational Inventory; S5= Session 5, S10= Session 10, S15= Session 15, S20= Session 20; SD= Standard Deviation

A similar finding is observed for B-LRI scores across sessions. Mean levels of client-perceived therapist conditions were closely aligned across samples at Session 5, with marginally higher means in the refined sample from Session 10 onward, most notably at Session 15. Despite these small differences, both samples show the same overall pattern of increasing B-LRI scores across sessions. SD for both AS and B-LRI were comparable across samples, with slightly lower variability in the refined sample at some time points, suggesting that attrition did not substantially alter score dispersion. Therefore, the descriptive statistics indicate a high degree of similarity between the n=40 and n= 59 in terms of central tendency and variability for both authenticity and client-perceived

therapist conditions. These findings suggest that the n = 40 subsample is broadly representative of the larger n= 59 sample, supporting its use for subsequent correlational and regression analyses.

Figure 6.2: Cross-lagged Correlation Between B-LRI and AS Across Four Time Points
(n=40)



Note. n=40; *CLC*=Cross-lagged correlation; *Authenticity*= Authentic Scale, *B-LRI*= Barret Lennard Relational Inventory, Scale; T *S5*= Session 5, *S10*= Session 10, *S15*= Session 15, *S20*= Session 20

Figure 6.2 illustrates the relationships between clients' perceptions of the three therapists' conditions and clients' authenticity across four time points: sessions 5, 10, 15, and 20. It shows positive correlations between B-LRI and AS

across most time points, indicating that a more robust perception of the therapeutic relationship tends to predict later authenticity levels over time.

Across both samples, the CLCs show strong autoregressive stability within each construct, with earlier B-LRI scores moderately to strongly correlated with later B-LRI scores, and authenticity showing consistent stability across sessions. In both the full samples (n= 59) and (n= 40), cross-lagged associations from authenticity to later perceptions of the therapist's conditions are weak and inconsistent, providing no evidence for reciprocal influence over time.

However, important differences emerge when comparing the two samples. In the larger sample (n= 59), CLC between B-LRI and authenticity are sparse and selective. Associations with later authenticity are primarily evident for B-LRI at Session 5, with no consistent cross-lagged associations observed from B-LRI at Sessions 10 or 15 to authenticity at later time points. The strongest cross-lagged association occurs between B-LRI at Session 5 and authenticity at Session 15 ($r = .36$, $p < .05$), indicating a limited and temporally distant association rather than a sustained cross-session pattern.

In contrast, the refined sample (n= 40) shows a clearer and more coherent cross-lagged pattern. While early B-LRI at Session 5 again demonstrates associations with later authenticity, these associations are stronger and more consistently observed across early and mid-phases of therapy. The direction of effects remains asymmetric, with client-perceived therapist conditions preceding authenticity rather than the reverse, but the temporal signal is less fragmented than in the larger sample.

Therefore, the comparison between Figure 6.1 and 6.2 suggests that both samples follow the same directional pathway—early client-perceived therapist conditions are more reliably related to later authenticity than authenticity is to

later relational perceptions. However, these findings are less pronounced in the n= 59 sample, whereas they are consistently observed in the refined n= 40 sample, indicating a stronger inferential temporal signal when longitudinal continuity is maintained (Kenny, 1975). Earlier B-LRI scores were almost consistently linked with later levels of authenticity, but this was not the case in the n= 59 sample, suggesting more reliable scores within the smaller sample.

On this basis, Tables 6.8–6.10 present the multiple regression applied across three successive session intervals: early-mid phase (Sessions 5–10), mid-late phase (Sessions 10–15), and termination phase (Sessions 15–20). These results. Relative to the n= 59 analyses (Tables 6.4–6.6), the n = 40 subsample shows a clearer, more consistent pattern of cross-session associations between client-perceived therapist conditions and subsequent authenticity.

Table 6.8: Early-Mid Phase: B-LRI Predicting Authenticity at Session 10 (N = 40)

		Unstandardised coefficients		Standardised coefficients		95% CI for β		
Model		B	SE	β	t	Lower	Upper	R^2
1	(constant)	38.5	4.92	0	0	-0.31	0.31	
	B-LRI S5	0.19	0.07	.33a	2.68	0.02	0.64	.11a
2	(constant)	16.63	6.98	0	0	-0.25	0.25	
	B-LRIS5	0.04	0.11	0.09	0.42	-0.36	0.55	
	AS S5	0.58	0.14	.56b	4.14	0.28	0.83	.43b
	B-LRIS10	0.07	0.1	0.15	0.7	-0.29	0.59	

Note. n=40; *AS*= Authentic Scale, *B-LRI*= Barret Lennard Relational Inventory; *S5*= Session 5; *S10*= Session 10; *SE*= Standard error, *CI*= Confidence Interval; *ap*< 0.05, *bp*<0.01

In the early–mid phase, therapist conditions at Session 5 continue to predict authenticity at Session 10 in the n= 40 sample (Table 6.8), with a slightly

stronger effect (β = .33) than in the full sample (Table 6.4). As in the n= 59 analyses, this association diminishes once baseline authenticity is considered; however, the early relational signal remains more prominent in the n= 40 subsample, indicating that greater dyadic consistency enhances the detection of early delayed effects.

A key difference appears in the mid-late phase. Unlike the n= 59 sample, where clients' perceptions of the three therapist conditions at Session 10 did not predict levels of authenticity at Session 15 (Table 6.5), the n= 40 analyses reveal a significant delayed association when therapist conditions at Session 10 are considered alone (Table 6.9; β = .33). This suggests that, when client–therapist dyads are temporally aligned and data are complete, relational perceptions continue to hold predictive value beyond the early phase of therapy. As with n=59, this effect diminishes when prior authenticity is included, with authenticity at Session 10 remaining the primary predictor.

Table 6.9: Mid-Late Phase: B-LRI Predicting Authenticity at Session 15 (N = 40)

		Unstandardised coefficients		Standardised coefficients		95% CI for β		
Model		B	SE	β	t	Lower	Upper	R^2
1	(constant)	39.38	5.8	0	0	-0.31	0.31	
	B-LRI S10	0.16	0.07	.33a	2.16	0.02	0.64	.11a
2	(constant)	5.61	5.15	0	0	-0.83	16.07	
	B-LRI S10	-0.04	0.08	-0.08	-0.48	-0.2	0.12	
	AS S10	0.84	0.1	.82b	8.64	0.65	1.04	.71b
	B-LRI S15	0.07	0.07	0.16	1	-0.07	0.22	

During the termination phase, clients' perceptions of the three therapist conditions at Session 15 did not independently predict authenticity at Session 20, even when prior authenticity was taken into account (see Table 6.6). However, in the n=40 subsample, therapist conditions at Session 20 were significantly linked to authenticity at that session (Table 6.10; β = .31), though this association was weaker and less consistent in the n=59 sample. This suggests that clients' views of relational patterns during termination more clearly reflect their authentic functioning when dyadic continuity is maintained across sessions.

Table 6.10 Termination Phase Multiple Regression Predicting Authenticity at Session 20 (N = 40)

		Unstandardised coefficients		Standardised coefficients		95% CI for β		
Model		B	SE	β	t	Lower	Upper	R^2
1	(constant)	42.2	6.4	0	0	-0.32	0.32	
	B-LRI S15	0.12	0.08	0.23	1.48	-0.09	0.55	0.1
2	(constant)	0.55	5.45	0	0	-0.23	0.23	
	B-LRI S15	-0.11	0.07	-0.17	-1.4	-0.43	0.08	
	AS S15	0.96	0.1	.46b	3.77	0.21	0.7	.75b
	B-LRI S20	0.12	0.08	.31a	2.53	0.07	0.56	

Note. n=40; *AS*= Authentic Scale, *B-LRI*= Barret Lennard Relational Inventory; *S15*= Session 15; *S20*= Session 20; *SE*= Standard error, *CI*= Confidence Interval; *ap*< 0.05, *bp*<0.01

Across both samples, authenticity demonstrated substantial stability over time. Early levels of authenticity appeared to provide the baseline from which later authenticity developed, reflecting initial levels of incongruence, that is, misalignment between the real and ideal self (Condition 2). Rather than emerging anew at later stages, authenticity seemed to evolve progressively as therapy unfolded. This finding aligns with developmental accounts of congruence

as a cumulative process shaped by relational experience (Grafanaki & McLeod, 2002; Stephen, 2023; see also Behr, 2009; Grafanaki, 2013; Greenberg & Geller, 2001).

Comparison of Tables 6.4–6.6 with Tables 6.8–6.10 indicates that restricting analyses to the n = 40 subsample did not alter the overall pattern observed in the full sample, but improved detection of delayed relational effects. In particular, the n = 40 analyses revealed a significant association between therapist conditions at Session 10 and authenticity at Session 15 (Table 6.9), which was absent in the n = 59 sample (Table 6.5). This suggests that limitations in the full sample may partly reflect disruptions in dyadic continuity and data completeness. Whereas the n = 59 findings were largely confined to the early phase of therapy, the n = 40 subsample showed associations extending into the mid phase, supporting its suitability for subsequent CLPD.

This stability highlights the need to distinguish genuine developmental continuity from artefactual sources of association. Controlling for earlier authenticity in the regression models was therefore methodologically necessary, reducing the risk that early effects were inflated by a halo effect, whereby initial ratings of the therapist or relationship reflect first impressions rather than sustained relational experience (Barrett-Lennard, 2015; Horvath, 2018). As therapy progresses, client perceptions may become more discerning and grounded in ongoing engagement.

At the same time, aspects of the measurement design may also have contributed to session-to-session consistency. Repeated use of the same measures can introduce construct-irrelevant variance, making stability appear stronger than it truly is (Matheson, 2019). Clients may also become less attentive when repeatedly completing lengthy forms such as the B-LRI and AS. Even with

five-session intervals, repeated exposure may encourage habitual responding and inflate autoregressive carry-over.

Taken together, these findings suggest that associations between earlier therapist conditions and later authenticity cannot be interpreted without accounting for substantial autoregressive effects. Structural equation modelling (SEM) was therefore an appropriate next step, as it enables direct estimation of temporal stability while testing whether client-perceived therapist conditions explain additional variance in later authenticity beyond prior levels. Accordingly, the second aim of the pilot study was to assess the feasibility of estimating a four-wave cross-lagged panel model across Sessions 5, 10, 15, and 20.

6.3.2 Initial Attempts with SEM and Challenges

A CLPD was implemented in RStudio using the lavaan package to examine longitudinal relationships between clients' perceptions of the three therapist's conditions (B-LRI) and their later level of authenticity (AS) across four time points (Sessions 5, 10, 15, and 20). Initially, both constructs were specified at the latent level, with all 40 B-LRI items and 12 AS items entered individually at each session as indicators of session-specific latent factors (e.g., LatBLRIS5, LatASS5). This item-level approach was intended to model shared variance across indicators while accounting explicitly for measurement error.

Path analysis within the SEM framework was then used to estimate directional and temporal associations between B-LRI and AS across therapy. Given the strong continuity observed in authenticity across sessions, lagged paths were estimated while controlling for autoregressive effects (e.g., AS at Session 5 and B-LRI at Session 5 predicting AS at Session 10).

One challenge encountered while creating the CLPD was formulating the latent variable. Several attempts were made to create a latent variable by

computing an aggregated equation using the individual items (e.g., the 40 items from B-LRI and the 12 items from AS) into an index for each session. However, no significant estimated coefficients were produced. This issue indicates that the latent-variable model imposed a significant computational burden. For instance, the model required 300 iterations to converge. That is because the optimiser struggled to find a solution. The specified multiple timepoint model may be too complex to conform well to the assumed structural relationships. One reason for this could be the difficulty of combining the 40 items from B-LRI into a coherent index. The interaction between these numerous items in a small sample (n=40) did not converge on estimated coefficients due to overfitting and numerical instability. The difference between the number of observations (nobs) and variables (nvar) across various time points was a significant concern when proceeding with SEM. It became clear that a larger sample size was needed to reach the estimated coefficient in the CLPD.

To address this issue, the scoring strategy was revised by replacing item-level indicators with total (sum) scores for each construct at each session (e.g., SumBLRI5; SumAS5), treated as observed variables. This reduced the number of variables from 208 to 8 and prioritised temporal estimability over measurement granularity, allowing the feasibility of a four-wave CLPD to be assessed within the available sample (Kenny, 1984).

The simplified four-wave model showed strong autoregressive effects within both constructs. Clients' perceptions of Rogers' three therapist conditions at Session 5 strongly predicted B-LRI at Session 10 ($\beta = 0.86$, $p < .001$) and Session 15 ($\beta = 0.90$, $p < .001$). B-LRI at Session 15 also predicted B-LRI at Session 20 ($\beta = 0.66$, $p < .001$). Similarly, authenticity demonstrated substantial continuity over time, with earlier scores significantly predicting later scores across successive waves.

In contrast, cross-lagged effects between B-LRI and authenticity were generally non-significant. For example, B-LRI at Session 5 showed only a marginal association with authenticity at Session 10 (β = 0.10, p = .08), while authenticity at Session 5 did not significantly predict B-LRI at Session 10 (β = -0.03, p = .52). This pattern suggests that both constructs primarily predicted themselves over time, with limited evidence of reciprocal cross-construct influence within the four-wave model.

Residual covariance between B-LRI and AS at Session 5 was significant, indicating shared variance at baseline not fully explained by the specified directional paths. Significant intercepts across time points further suggested that both constructs began from meaningful, non-random starting levels that persisted across sessions. However, the dominance of autoregressive effects meant that temporal stability accounted for much of the available variance, leaving limited power to detect cross-lagged associations in a modest sample.

Accordingly, the four-wave CLPD was judged to have limited interpretive value. Strong autocorrelation across adjacent waves introduced multicollinearity and reduced the model's capacity to estimate unique longitudinal effects. Evidence from the correlation matrices shown in Figures 6.1 and 6.2 indicated that the most informative delayed association occurred between clients' perceptions of therapist conditions at Session 5 and authenticity at Session 15 across both samples. This early-to-middle phase transition appeared to capture the clearest temporal separation in the data.

The longitudinal model was therefore refined to focus on Sessions 5 and 15 only. This decision reduced redundancy while retaining the most empirically robust temporal association. Sessions 10 and 20 were excluded from subsequent analyses because of their high overlap with adjacent waves and their limited additional temporal information.

6.4 Conclusion

In conclusion, this chapter established that the HFP dataset was suitable for longitudinal modelling using a reduced cross-lagged framework centred on two theoretically and empirically salient time points: clients' perceptions of the three therapist conditions at Session 5 and authenticity at Session 15. Preliminary analyses indicated substantial temporal stability in both constructs, with early authenticity functioning as an important autoregressive component and early therapist perceptions showing the most consistent associations with later authenticity.

For cross-lagged analysis, total scores of the B-LRI and AS were retained rather than latent item-level variables. This decision was guided by sample size constraints and model feasibility, as a full latent specification substantially increased complexity and risked non-convergence. While the use of total scores limited direct modelling of measurement error, it enabled more stable estimation of temporal relations within the available data. These findings therefore provided the empirical and methodological foundation for the longitudinal analyses presented in the subsequent chapter.

Two considerations remain important when interpreting these results. First, the present analyses explored directional relationships at the group level within the limits of the available sample. In addition, some therapists worked with more than one client, meaning observations may not have been fully independent. Client scores may therefore have been partly shaped by therapist-level factors such as relational style or consistency. Larger samples would permit multilevel or Bayesian longitudinal models capable of accounting for clients nested within therapists, alongside modelling individual differences, non-linear change, and more complex relational processes. Second, formal longitudinal

measurement invariance testing was not feasible. The following chapter therefore presents a CLPD across two time points.

Chapter 7: Results: *Earlier Client Perceptions of Rogers' Three Therapist Conditions and Later Authenticity: A Cross-Lagged Panel Correlation Analysis*

7.1 Introduction

Chapter 6 showed that clients' perceptions of the three therapist conditions were positively associated with authenticity across therapy. However, these associations did not establish directionality. It remained unclear whether earlier relational perceptions contributed to later authenticity, whether authenticity shaped later perceptions of the therapist, or whether both constructs simply reflected stability over time. The present chapter therefore examines temporal ordering.

To address this question, a two-wave cross-lagged panel design (CLPD) was estimated using Structural Equation Modelling (SEM), focusing on Session 5 and Session 15. Session 5 represented an early phase of therapy in which psychological contact was likely established and clients had sufficient exposure to the therapeutic relationship. Session 15 represented a later phase in which movement toward authenticity may be more observable. This wider interval also provided stronger temporal separation than adjacent-session analyses.

The CLPD further offered a structured means of translating Rogers' directional hypothesis into an empirical model. Within the Human Flourishing Project research clinic, Conditions 1 and 2 were treated as prerequisites at entry to therapy. Conditions 3 to 6 were operationalised through client ratings of the

therapist conditions using the Barrett-Lennard Relationship Inventory (B-LRI). Authenticity, measured by the Authenticity Scale (AS), was treated as an indicator of greater congruence, reduced alienation, and closer alignment between lived experience and self-concept. By locating relational perceptions earlier in time and authenticity later, the model enabled examination of Rogers' proposed developmental sequence. 40 clients completed both measures at Sessions 5 and 15, allowing repeated assessment of construct stability and temporal precedence. The analysis tested whether stronger early relational perceptions were associated with later authenticity, or whether the reverse pathway received greater support.

Findings showed positive concurrent associations at both time points, alongside strong stability in each construct across time. After accounting for this stability, earlier perceptions of the therapist conditions showed a small but significant association with later authenticity, whereas earlier authenticity was not associated with later relational perceptions. This pattern favoured the proposed Rogerian direction, although the difference between pathways was not statistically reliable.

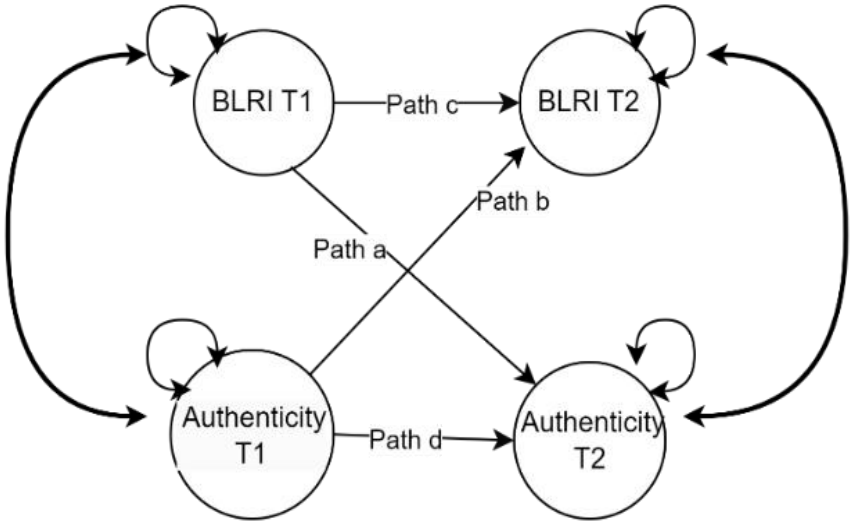
7.1.1 Testing Temporal Order Between B-LRI and AS

Figure 7.1 illustrates the two-wave cross-lagged panel design used to examine the temporal ordering between clients' perceptions of the three therapists' conditions and client authenticity. The model includes two observed variables—B-LRI and authenticity—each measured at two time points: Session 5 (T_1; early phase) and Session 15 (T_2; late phase).

The CLPD simultaneously estimates autoregressive, cross-lagged, and synchronous covariances within a single analytic framework. This structure

allows temporal prediction to be examined while controlling prior levels of each construct (Kenny, 1975; Selig & Little, 2012).

Figure 7.1 Two-Wave Path Diagram Between B-LRI and Authenticity In CLPD



Note. Authenticity = Authentic Scale, B-LRI = Barret Lennard Relational Inventory; T1 =Session 5, T2 = Session 15; Curved double-headed arrows attached to each variable represent residual variances of the observed constructs at each time point.

Two autoregressive paths are specified. Path *c* represents stability in clients' perceptions of the three therapists' conditions from Session 5 to Session 15, while Path *d* represents stability in authenticity across the same period. These paths index rank-order stability over time and are essential for interpreting cross-lagged effects as prediction beyond what would be expected from prior levels alone.

Two cross-lagged paths are estimated. Path *a* illustrates the effect of clients' perceptions of the three therapists' conditions at Session 5 on

subsequent authenticity at Session 15, while controlling for prior authenticity. A significant effect on path *a* will suggest that earlier perception of the three therapists' conditions predicts later levels of authenticity, supporting Rogers' temporal sequence. Path *b* reflects the reverse cross-lagged effect, testing whether earlier authenticity predicts later perceptions of the three therapists' conditions. A non-significant effect on path *b* indicates that the client's earlier authenticity levels do not predict their later perception of the three therapists' condition.

Synchronous associations between B-LRI and AS at each time point are modelled as correlations, represented by double-headed arrows. These covariances capture contemporaneous alignment between relational perception and authenticity measured within the same session and are included to prevent cross-lagged effects from being inflated by same-session associations.

Curved double-headed arrows attached to each observed variable represent residual variances, reflecting variance not explained by the predictors specified in the model. These are included as standard components of the CLPD rather than as substantive hypotheses. Significant residual variance indicates that variance remains unexplained by the model, whereas non-significant residual variance suggests that the specified predictors account for most of the variance at that time point. Accordingly, later authenticity is therefore examined in relation to earlier authenticity while allowing unexplained variance to remain. This approach does not assess change through difference scores but examines whether earlier client-perceived relational conditions are associated with later levels of authenticity beyond expected temporal stability.

In summary, comparing path *a* and *b* allows evaluation of whether the association between B-LRI and AS is unidirectional, reciprocal, or absent, thereby addressing spuriousness associations. A significant asymmetry between the two

paths indicates unequal temporal influence. When no asymmetry is observed, the association may reflect shared stability or the influence of unmeasured third variables rather than a direct temporal relationship. In summary, the path diagram in Figure 7.1 incorporates the six conditions to assess the directional ordering that supports the sufficiency component of Rogers' hypothesis by placing the therapist's conditions at the start of the process rather than as outcomes of the client's previous state. The next section applies this path diagram to the HFP sample, describing the participants and the analytic procedures used to estimate the CLPD.

7.2 Methods

This study involved a secondary analysis of data drawn from the HFP research clinic. The sample comprised 40 clients and 19 therapists with complete B-LRI and AS data at both sessions. Demographic characteristics are reported in Table 7.1. The client sample was predominantly female (26 women; 65.0%), with 12 men (30.0%), and the therapist sample was also predominantly female (15 women; 78%; 4 men; 22%). Outliers were examined and retained (see Figure 7.2).

Tables 6.1 and 7.1 show that the n = 59 and n = 40 samples are comparable in age, gender, ethnicity, and presenting concerns. Differences between the samples are therefore not attributable to client characteristics. The reduction from the full sample to the longitudinal subsample primarily reflects research data completeness requirements, including the availability of session audio recordings required for process coding. Audio recording formed part of the research protocol and was obtained at the therapist level. As a result, some client–therapist dyads were excluded due to missing recordings, despite clients completing self-report measures.

Table 7.1: Demographics

	Clients (N=40)	Therapists (N= 19)	Clients Concern	%
Gender				
Female	26 (65.00%)	15 (78%)	Depression and anxiety	10 (25.00%)
Male	12 (30.00%)	4 (22 %)	Trauma	4 (10.00%)
Non-Binary	1 (2.50%)	0 (0%)	Depression	7 (17.50%)
Trans Man	1 (2.50%)	0 (0%)	Suicidal idealisation	4 (10.00%)
Age (Mean/SD)	38.0 (12.0)	N/A	Anxiety	3 (7.50%)
Ethnicity			Addiction	2 (5.00%)
White British	34 (85.00%)	10 (50%)	Self-esteem	2 (5.00%)
Asian	1 (2.50%)	5 (25%)	Trauma and Depression	1 (2.50%)
Black Caribbean	1 (2.50%)	1 (5%)	Anxiety and Trauma	2 (5.00%)
Mixed British German	1 (2.50%)	0 (0%)	Anxiety, Trauma and Depression	2 (5.00%)
White European	0 (0%)	2(10%)	Eating disorder	1 (2.50%)
N/A	3 (7.50%)	1 (5%)	NA	2 (5.00%)
Duration in *months* (Mean/SD)	9.86 (2.95)			
Client-therapist Match				
1	1(20%)	8 (42.11%)		
2	2(15%)	3 (15.79%)		
3	3(45%)	6 (31.58%)		
4	4(20%)	2 (10.52%)		

Note. n= 40; N/A= Not Available, SD=Standard Deviation; N= The frequency number

This exclusion disproportionately affected single client–therapist dyads.

Table 7.2 shows that therapists who worked with multiple clients were more likely to remain represented in the longitudinal subsample. In contrast, 6 therapists who worked with only one client were more vulnerable to exclusion when research procedures were inconsistently implemented across sessions.

Restricting the analyses to the n = 40 subsample therefore reduced procedural heterogeneity related to research implementation. The improved coherence and stability of the longitudinal results suggest that synchronisation of research procedures, rather than client or therapist characteristics, was critical for reliably modelling temporal relationships.

Table 7.2: Distribution of therapy sessions before ending Therapy

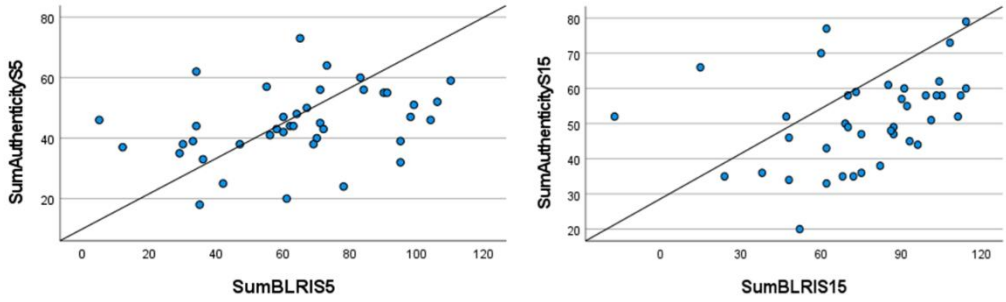
Clients (N=)	Frequency	Percentage
20	12	30.00%
21	1	2.50%
22	2	5.00%
23	1	2.50%
24	2	5.00%
25	3	7.50%
26	1	2.50%
28	4	10.00%
30	1	2.50%
32	1	2.50%
33	1	2.50%
34	1	2.50%
37	2	5.00%
38	1	2.50%
40	8	20.00%

Note. This table presents the distribution of the total number of therapy sessions completed by 40 clients before ending therapy. Frequencies and percentages reflect the number of clients completing therapy at each session count.

7.3 Results

This section presents results examining temporal relations between clients' perceptions of the three therapist conditions and authenticity across Sessions 5 and 15 (n = 40).

Figure 7.2 Scatterplots between AS and B-LRI at sessions 5 and 15



Note. n=40

Figure 7.2 indicates positive concurrent associations between B-LRI and authenticity at both time points. At Session 5, the relationship was moderate and significant ($r = .33$, $p < .05$). A comparable association was observed at Session 15 ($r = .32$, $p < .05$). Across both stages, clients who perceived stronger therapist conditions tended to report higher authenticity.

Table 7.3 presents the descriptive statistics and correlations for Sessions 5 and 15. Mean B-LRI scores increased from 64.18 (SD = 26.02) at Session 5 to 75.82 (SD = 28.79) at Session 15, suggesting more favourable perceptions of the therapist conditions over time. Mean authenticity scores also increased from 44.65 (SD = 11.89) to 51.15 (SD = 12.54), reflecting a moderate standardised increase (Cohen's $d \approx 0.52$).

Table 7.3: Means, standard deviation, and bivariate correlation among

authenticity and B-LRI score

Variable	1	2	3	4	M	SD
1. Authenticity Session 5		.33a	.73b	0.19	44.65	11.89
2. B-LRI Session 5			.44a	.78b	64.18	26.02
3. Authenticity Session 15				.32a	51.15	12.87
4. B-LRI Session 15					75.82	28.79

Note. n=40; AS= Authenticity Scale, B-LRI= Barret-Lennard Relational Inventory, Scale; S5= Session 5, S15= Session 15; M= Mean, SD=Standard Deviation; ap< 0.05, bp<0.01

Standard deviations remained broadly similar across sessions, indicating stable variability over time. Variability was greater for B-LRI than authenticity, suggesting wider individual differences in how clients perceived the therapist conditions than in how they reported authenticity.

Temporal stability was evident for both constructs. Authenticity at Session 5 was strongly associated with authenticity at Session 15 ($r = .73$, $p < .01$), and B-LRI at Session 5 was strongly associated with B-LRI at Session 15 ($r = .78$, $p < .01$). These findings suggest relative continuity in both variables across therapy.

The cross-lagged correlation between B-LRI at Session 5 and authenticity at Session 15 was significant ($r = .44$, $p < .05$), indicating that stronger early perceptions of the therapist conditions were associated with higher later authenticity. By contrast, authenticity at Session 5 showed a weaker non-significant association with B-LRI at Session 15 ($r = .19$), providing preliminary support for an asymmetrical pathway later tested within the SEM model.

Table 7.4. Temporal Associations Between Perceived Therapist Conditions and Client Authenticity Across Sessions 5 and 15

Path Diagram	Predictor(s) → Outcome	β	SE	z
Path *a*	$B\text{-}LRI_5 + AS_5 \rightarrow AS_{15}$	0.1a	0.05	2.06
Path *b*	$AS_5 + B\text{-}LRI_5 \rightarrow B\text{-}LRI_{15}$	−0.12	0.28	−0.43
Path *c*	$B\text{-}LRI_5 \rightarrow B\text{-}LRI_{15}$	0.82b	0.13	6.46
Path *d*	$AS_5 \rightarrow AS_{15}$	0.77b	0.11	7.04
Covariance	$(B\text{-}LRI_5 \leftrightarrow AS_5)$	99.19a	50.23	1.98
Residual covariance	$(B\text{-}LRI_{15} \leftrightarrow AS_{15})$	15.85	23.66	0.67

Notes. *n*=40; Path *a* and Path *b;* Two Cross-lagged Paths; Path *c* and Path *d*; Two autoregressive Paths; *AS*= Authenticity Scale, *B-LRI*= Barret-Lennard Relational Inventory; S*5*= Session 5; S*15*= Session 15; β; Standardised coefficient; *z* = Wald test statistic; *a*p< 0.05, *b*p<0.01

Table 7.4 presents the cross-lagged panel estimates examining temporal associations between clients' perceptions of the three therapists' conditions and authenticity across Sessions 5 and 15.

Paths c and d were large and statistically significant, indicating substantial temporal stability in both constructs across the measured interval. Earlier perceptions of the three therapists' conditions strongly predicted later B-LRI scores (β = .82, p < .01), while earlier authenticity strongly predicted later authenticity (β = .77, p < .01). These findings suggest that individual differences in both variables remained relatively stable over time.

After accounting for these autoregressive effects, Path a showed a small but statistically significant cross-lagged association from B-LRI at Session 5 to authenticity at Session 15 (β = .10, p < .05). This indicates that stronger early perceptions of the three therapists' conditions were associated with modestly higher later authenticity, beyond prior authenticity levels. Although statistically reliable, the magnitude of this coefficient was small, suggesting limited incremental predictive influence within the overall model.

In contrast, Path b, representing the reverse pathway from authenticity at Session 5 to B-LRI at Session 15, was not statistically significant (β = −.12, ns), indicating that earlier authenticity was not reliably associated with later perceptions of the three therapists' conditions.

The covariance between B-LRI and authenticity at Session 5 was statistically significant, indicating a concurrent association at the early phase of therapy. By contrast, the residual covariance at Session 15 was non-significant after accounting for autoregressive and cross-lagged effects.

Comparison of the two cross-lagged coefficients showed a numerical difference in magnitude (Δβ = .22), with only the pathway from earlier B-LRI to later authenticity reaching statistical significance. However, the difference between these directional effects was itself non-significant (z = 0.78), indicating no reliable evidence that one pathway was stronger than the other.

7.4 Discussion

The present study examined Rogers' (1957, 1959) six necessary and sufficient conditions over time by testing whether earlier relational conditions were associated with later client outcomes. The findings indicate a modest and asymmetric temporal pattern in which clients' earlier perceptions of the three therapists' conditions were associated with later authenticity more consistently than the reverse pathway. Earlier authenticity did not show a comparable association with later perceptions of the three therapists' conditions. However, the difference between the two cross-lagged paths was not statistically significant and should therefore be interpreted cautiously.

The absence of a statistically reliable reverse pathway suggests that earlier authenticity may be less directly implicated in shaping subsequent

perceptions of the therapeutic relationship within the time frame examined. Prior research has more commonly identified client-perceived relational conditions as antecedent variables associated with later engagement and outcomes, rather than showing that early symptom presentation or authenticity predicts later relational perception. The present findings therefore align with a broader literature linking early perceptions of the therapeutic relationship to subsequent outcomes across therapeutic modalities and clinical contexts (Carl Rogers, 1962/2015; Blatt et al., 1996; Elkin et al., 2014; Murphy & Cramer, 2014; Bayliss-Conway et al., 2021).

At the same time, the CLPD design does not eliminate the possibility of shared variance, omitted variables, or reciprocal influences operating outside the measured interval. The absence of a significant reverse path does not imply that authenticity plays no role in the therapeutic relationship. Rather, it suggests that authenticity was not the stronger prospective predictor of later relational perception within this model. The temporal spacing of assessments may also be relevant. Authenticity was assessed across a ten-session interval, which may be insufficient to capture slower developmental changes. Sohal and Murphy (2022), for example, reported that clients often describe clearer shifts in authenticity later in therapy, commonly around Session 20. Accordingly, the observed pathway from early relational perception to later authenticity is better understood as one part of a broader developmental process than as evidence of a direct causal sequence.

The magnitude of the observed cross-lagged association was small. This is consistent with prior research showing that early B-LRI scores typically predict later outcomes with modest effect sizes, often ranging between .15 and .35 (Blatt et al., 1996; Bell et al., 2016; Bayliss-Conway et al., 2021). Such findings suggest that relational process variables may exert meaningful yet non-

deterministic influences on therapeutic change. In this context, the modest coefficient observed in the present study is not anomalous, but broadly consistent with the wider psychotherapy process literature.

Further evidence indicates that the impact of early client-perceived therapist conditions is unlikely to operate uniformly across individuals. Factors such as initial distress, self-critical perfectionism, interpersonal engagement, and early participation have been shown to moderate the relationship between early relational perception and later outcomes (Zuroff et al., 2000; Zuroff et al., 2010; Zuroff et al., 2016; Dolev & Zilcha-Mano, 2019). These influences may help explain variability in the present findings and highlight the importance of client readiness, relational history, and emotional openness.

Consistent with this interpretation, early B-LRI scores have been associated with continuation in therapy, behavioural involvement, and lower dropout rates (Kolb et al., 1985; Beckham, 1992; Elkin et al., 1999; Elkin et al., 2014), as well as later outcomes related to symptoms and authenticity (Blatt et al., 1996; Payne et al., 2007; Bayliss-Conway et al., 2021). These findings suggest that early client-perceived relational conditions may help shape the therapeutic context within which later outcomes emerge. Early perception may therefore reflect more than initial psychological organisation, contributing to a relational climate that supports emotional safety, participation, and sustained engagement.

However, early perceptions of the three therapists' conditions should not be understood as direct or uniform determinants of outcome. Clients differ in their receptivity to, recognition of, and capacity to use these conditions. For some, early experiences of empathy, congruence, and unconditional positive regard may facilitate openness and sustained engagement. For others, difficulties with trust, heightened defensiveness, or limited receptivity may constrain engagement or contribute to early withdrawal.

Engagement depends partly on the extent to which the three therapists' conditions help free the client toward their actualising tendency. It reflects both the client's capacity to enter psychological contact, tolerate vulnerability, and engage with inner experience, and the therapist's capacity to enter the client's internal frame of reference and understand implicit experiencing. For the actualising tendency to be freed, congruence must be lived and experienced within the relationship. Experiencing congruence can therefore be understood as an evolving, co-created process requiring openness, self-awareness, and meaningful relational contact from both participants.

This emphasis on lived relational engagement is consistent with dialogical perspectives in psychotherapy. Buber's (1970) assertion that "all real life is encounter" and Schmid's (2001) view that therapist and client are not merely in relationship but are relationship itself both foreground the transformative potential of authentic encounter. Within this view, empathy, unconditional positive regard, and congruence are not simply perceived but experienced. Through the therapist's sustained attempt to understand the client's internal frame of reference as lived, implicit meanings may gradually be sensed, symbolised, and brought into awareness.

Within such dialogue, moments of incongruence may become opportunities for growth. Kolden et al. (2011) noted that alienated clients often rely on defence mechanisms, role-playing, or façades of expertise. When these patterns are met with empathic understanding grounded in the client's internal frame of reference, they may become openings through which deeper self-contact and emotional openness emerge. The therapist's empathic understanding can support emotional safety and expression of previously disowned experience by communicating that the client's meanings are heard and valued. Unconditional positive regard may reduce incongruence by loosening

conditional acceptance, while therapist congruence may model authenticity and invite reciprocal openness. Together, these conditions may support movement toward greater alignment between lived experience and self-concept.

Within this relational framework, person-centred therapy is grounded in the actualising tendency, relational helping, and optimal functioning (Joseph & Murphy, 2013). As reliance on external validation diminishes, clients may increasingly trust their felt sense, align with intrinsic values, and move toward greater authenticity and congruence as more fully functioning persons. Rogers (1961) conceptualised this movement as a developmental process marked by increasing openness and internal congruence, while offering limited detail regarding how such changes are subjectively lived within therapy.

Gendlin et al. (1960) addressed this gap by demonstrating that clients with poorer outcomes often participate in dialogue without turning inward, relying on explanation or narrative rather than felt experience. Experiencing captures the extent to which clients attend to, symbolise, and integrate felt experience within the therapeutic encounter. This is consistent with Rogers' view that the therapist does not direct change but provides relational conditions under which the client's experiential process can unfold (Gendlin & Zimring, 1955). Change may occur when implicit meanings emerge and are carried forward within dialogue.

Therefore, experiencing offers a plausible process link between early relational perception and later authenticity. The absence of a reciprocal pathway suggests that authenticity may not directly shape later relational perception, but may instead develop through how clients use the relational climate over time. Process research indicates that experiencing patterns often consolidate during the middle phase of therapy, following alliance formation and preceding termination (Watson, 2011; Pos et al., 2009, 2017). Therefore, experiencing in

the mid-phase may represent a clinically meaningful point at which early relational conditions are translated into later authenticity, without assuming a linear or uniform developmental pathway.

7.5 Conclusion

In conclusion, the findings provide tentative support for a temporal sequence in which earlier client-perceived relational conditions are associated with later authenticity within a longitudinal panel framework. However, this association was modest in magnitude, and strong autoregressive paths indicated substantial stability within individuals across time. These findings suggest that early relational perception does not produce equivalent or rapid change in authenticity across clients.

Instead, the influence of early relational conditions appears to unfold gradually and may differ according to how clients receive, recognise, and make use of the therapist's empathy, congruence, and unconditional positive regard. Early perceptions of the three therapists' conditions may therefore be understood as one meaningful relational foundation within a wider change process rather than as sufficient determinants of outcome.

This chapter brings together all six of Rogers' necessary and sufficient conditions within a single longitudinal model and offers a novel empirical attempt to examine Rogers' proposed temporal ordering as an interconnected process. The findings refine Rogers' hypothesis by situating the pathway from relational conditions to authenticity within a process-oriented framework that emphasises sequential timing, individual variability, and the likely role of intervening processes.

The following chapter builds on these conclusions by examining how variations in clients' engagement with therapy may help account for later differences in authenticity.

Chapter 8: Results: *The Role of Client Experiencing in Mediating Early Perceptions of Rogers' Three Therapist Conditions and Later Authenticity*

8.1 Introduction

This chapter presents the results of a mediation analysis examining whether clients' experiencing during the middle phase of therapy functions as a process through which early perceptions of the therapist's facilitative conditions are associated with later movement toward greater authenticity. Mediation analysis is commonly used to examine whether associations between variables may operate through an intervening process over time (Jose, 2016; MacKinnon et al., 2007; Selig & Preacher, 2009). The present analysis is grounded in Carl Rogers (1957, 1959) hypothesis that constructive personality development arises when a facilitative relational climate is genuinely present and perceived by the client.

The therapist's core relational conditions do not operate as techniques that directly produce development. Rather, these relational attitudes establish the circumstances under which the client's actualising tendency may operate more freely. Constructive movement is understood to unfold through the client's lived engagement with inner experience, characterised by increasing psychological contact, greater openness to experience, reduced reliance on introjected conditions of worth, and gradual movement away from alienation toward congruence.

Previous analyses reported in Chapter 7 showed that clients' early perceptions of therapist conditions at Session 5 were associated with later

authenticity at Session 15, whereas the reverse pathway was not supported. Building on this finding, the present chapter examines whether that directional association operates through experiencing as a process variable.

As Selig and Preacher (2009) note, mediation requires that the proposed mediator is measured at a point that meaningfully lies between the predictor and the outcome. Following the longitudinal considerations outlined in Chapter 6, Session 5, Session 10, and Session 15 were identified as the most suitable time points for this purpose. Session 5 represents the earlier relational phase, Session 10 captures the middle phase of therapy, and Session 15 provides a later indicator of authenticity. This creates a shorter but conceptually coherent longitudinal sequence within which a single mediation model is tested.

The model specifies that early client perceptions of therapist conditions are associated with experiencing during the middle phase of therapy, and that experiencing, in turn, is associated with later authenticity. The middle phase of therapy is particularly suitable for assessing experiencing, as clients are often more able to engage in deeper exploration of felt experience at this stage (Pos et al., 2009; Pos et al., 2017).

The central hypothesis is that clients who perceive stronger therapist conditions early in therapy will demonstrate a more inward, receptive, and engaged manner of experiencing during the middle phase, which in turn will be associated with higher later authenticity. By contrast, clients who perceive weaker relational conditions are expected to show lower experiential engagement and less subsequent movement toward authenticity.

This chapter begins by presenting the mediation model. The results section first establishes the credibility of EXP scoring through inter-rater calibration and describes the distribution of mode and peak experiencing scores.

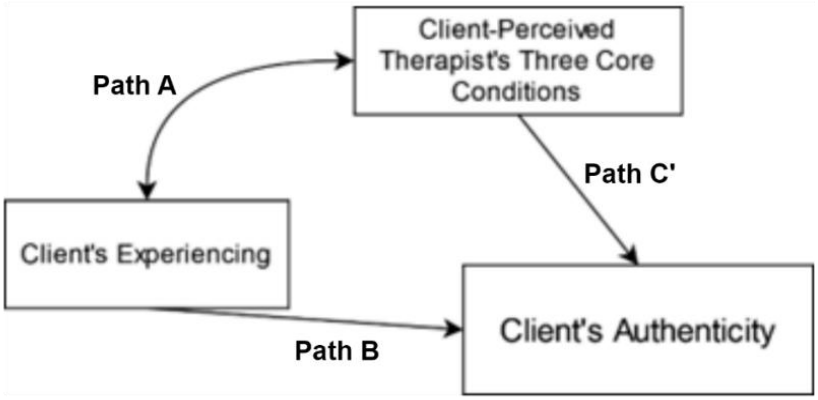
It then reports preliminary associations and regression analyses examining the contribution of early therapist conditions and mid-therapy experiencing to later authenticity.

A formal mediation model is then estimated to test whether EXP accounts for the association between early relational perception and later authenticity. Given the absence of linear mediation, the analysis then turns to level-specific effects using categorical regression. The chapter concludes with a cross-lagged analysis examining the temporal direction between perceived therapist conditions and receptivity to focusing inward on experience.

8.1.1 Identifying the Process Mechanism

Figure 8.1 presents the mediation model tested in this study and situates it within a temporally ordered therapeutic process. To meet the assumptions required for mediation, therapy was operationalised across three phases. Clients' perceptions of the three therapist conditions were assessed in the early phase of therapy, at Session 5, using the Barrett-Lennard Inventory of Relationship (B-LRI). The manner of experiencing was assessed in the middle phase of therapy at session 10 using the Experiencing scale (EXP). The clients' later levels of authenticity were assessed in the late phase of therapy at Session 15 using the Authenticity Scale (AS). Three pathways were specified: two indirect-effect paths (paths *a* and *b*), together constituting the indirect effect, and one direct pathway (path *c'*) representing the association between clients' early perceptions of the three therapist conditions and their later levels of authenticity, after accounting for their manner of experiencing during the middle phase of therapy.

Figure 8.1: Mediation Model



Note. Clients' perceptions of the three therapist conditions (B-LRI) were assessed in the early phase of therapy (Session 5); clients' manner of experiencing (EXP) was assessed in the mid-phase of therapy (Session 10); and clients' levels of authenticity (AS) were assessed in the later phase of therapy (Session 15). Path a represents the association between clients' perceptions of the three therapist conditions and their manner of experiencing; path b represents the association between the manner of experiencing and later authenticity; and path c' represents the direct association between clients' perceptions of the three therapist conditions and later authenticity, controlling for the manner of experiencing.

Path a (B-LRI → EXP) examines the relationship between the client's perception of the therapist's three conditions and their manner of experiencing. The double-headed arrow indicates a bidirectional association between B-LRI and

EXP regarding later levels of authenticity. If path a is significant, it suggests that the client's perception of the therapeutic relationship at Session 5 is associated with their higher level of experiencing at Session 10.

Path b (EXP → authenticity) reflects the extent to which experiencing relates to authenticity, testing whether clients' manner of experiential engagement during the mid-phase of therapy is associated with later authenticity levels. If path b is significant, it indicates that the client's experiencing level at Session 10 is associated with their authenticity score at Session 15.

Path c' (B-LRI → authenticity) represents the direct association between clients' perceptions of the three therapists' conditions in the early phase of therapy and their later levels of authenticity, controlling for experiencing. This pathway tests whether clients' perceptions of the therapeutic relationship at Session 5 are associated with authenticity at Session 15 independently of their level of experiencing at Session 10. If path c' is significant, it indicates that early B-LRI is associated with later authenticity over and above the contribution of the client's manner of experiencing.

Mediation is evaluated by estimating the indirect effect of B-LRI on authenticity through experiencing at Session 10, calculated as the product of paths *a* and *b* ($a \times b$). This mediation analysis examines whether experiencing represents one pathway through which the therapist's relational conditions are taken up by the client in the movement toward greater authenticity. A statistically significant indirect effect would indicate that experiencing accounts for part of the association between early relational perception and later authenticity, consistent with Rogers' view that a facilitative relational climate supports psychological change through the client's deepening engagement with experience. Conversely, a non-significant indirect effect would suggest that experiencing does not operate as a single, linear transmission pathway between

perceived therapist conditions and later authenticity but rather reflects a dynamic and developmental process that may unfold non-linearly, vary across clients, or interact with the relational climate in ways not fully captured by the present mediation model.

These pathways outline the structure of the mediation model discussed in this chapter and form the basis for analysing the empirical results. They place Rogers' six conditions within a timeline that connects relational perception, the experiencing process, and subsequent authenticity.

8.2 Method

This chapter draws on the same sample of clients (n = 40) and therapists (n = 19) as reported in Chapters 6 and 7 (see Tables 6.7, 7.1 and 7.2). Therapy was delivered within the Human Flourishing Project research clinic using a person-centred and experiential approach. Client assessments using standardised measures were carried out at Sessions 5, 10, and 15 to reflect the temporal structure required for the mediation analysis.

Measures

At Session 5, clients completed B-LRI, which provided self-ratings of their perceptions of the three therapists' conditions in the early phase of therapy. The global score of the B-LRI was used to assess clients' overall perceptions of the therapist's relational stance. Higher B-LRI scores indicate that clients perceived higher levels of therapist empathy, congruence, and unconditionality, and level of regard, whereas lower scores indicate lower perceived levels of these relational conditions.

At Session 10, client audio recordings were rated using the EXP. A seven-minute audio segment, extracted approximately thirty minutes into the session,

was selected for analysis. EXP ratings indexed the manner in which clients engaged with their inward emotional experience during the mid-phase of therapy. Both peak experiencing and mode experiencing were derived from these ratings. Mode experiencing reflects the client's predominant level of experiential engagement during the rated segment, whereas peak experiencing reflects the highest level of experiential depth achieved, consistent with Rogers' emphasis on moments of inward openness in the therapeutic process.

By Session 15, clients completed the AS, which assessed their sense of authenticity toward the termination phase of therapy. The global score was used to index clients' overall level of authenticity, reflecting the degree of alignment between inner experience and self-concept. Higher AS scores indicate higher levels of authenticity, characterised by reduced self-alienation, lower acceptance of external influence, and greater authentic living in alignment with inner experience and self-organisation, whereas lower scores indicate greater self-alienation and stronger organisation around conditions of worth. Collectively, these assessments measured the relational, process, and outcome aspects within Figure 8.1.

8.3 Results

8.3.1 Inter-rater Results

Inter-rater reliability for EXP scoring was examined during a calibration phase involving three independent raters: two Professors of Psychology and the primary rater. Following approximately 40 hours of training, the raters independently scored audio recordings from eight clients from the HFP sample across Sessions 1, 5, 10, 15, and 20. An initial inter-rater reliability assessment was then conducted, in which the primary rater's scores were compared with those of the senior raters to evaluate alignment with expert judgement. This

calibration process was designed to establish the reliability of the primary rater's EXP scoring before collecting and rating 70 audio recordings across time.

Five clients were selected at random from the pool of eight participants whose EXP scores were already available in the HFP dataset. Inclusion required the availability of audio recordings at Sessions 1, 5, 10, 15, and 20, although transcription availability varied across clients.

Two clients had all five sessions transcribed.

One client had four sessions transcribed, excluding session 1.

One client had only session 1 transcribed.

One client had sessions 5 and 20 transcribed.

This variation in session segments allowed representation across different stages of therapy while remaining feasible for detailed coding, though it limited uniformity in the material available for cross-case comparison. All 17 sessions were transcribed using headphones and a transcription pedal to support precise capture of clients' verbal and emotional expression.

Clients' EXP rating began with the primary rater, after which the senior raters received printed packs containing randomly ordered transcriptions of the selected audio segments. Each transcription comprised a seven-minute extract taken approximately 30 minutes into the session and was labelled numerically (1–17) to preserve anonymity. The order of the transcriptions, presented in Table 11.A in Appendix 11, was fully randomised so that raters could not identify the session number or the client's stage of therapy. All ratings were therefore completed blind to outcome.

The transcriptions included relevant nonverbal cues (e.g., smiling, laughing, coughing, and silence) to reflect the client's felt sense more accurately.

Repetitive filler words (e.g., “you know,” “yeah,” “hmmm”) were removed to avoid recognition of the client or the original session. Within each transcript, T’ marked therapist statements and ‘C’ marked client statements. Only client statements were rated. The number of client statements differed across transcripts: some contained only a few, while others contained more than 20. Each client statement was numbered clearly (e.g., C15 for the fifteenth statement). Examples of the transcriptions are provided in Appendix 12.

Each rater scored every client statement within each seven-minute transcription using the EXP scale. After the expert raters completed their ratings, the designated rater collected the booklets and calculated each rater’s modal rating (the level expressed most consistently across the segment) and peak rating (the deepest level reached). Appendix 11: Table 11.B reports these modal and peak scores. All data were entered into SPSS, and all printed materials were securely destroyed using the University’s shredding system.

Table 8.1 displays the inter-rater correlations for both mode and peak experiential (EXP) ratings across three independent raters. All pairwise correlations were statistically significant, indicating a consistent pattern of agreement among raters in their assessments of clients’ levels of experiencing.

For mode EXP, inter-rater correlations ranged from $r = .53$ to $.71$ ($p < .05$–$.01$), indicating moderate to strong agreement in ratings of clients’ overall levels of experiencing during sessions. For peak EXP, correlations ranged from $r = .60$ to $.65$ ($p < .01$), showing a comparable level of agreement in identifying clients’ highest moments of experiencing. Although the highest coefficient was observed for mode EXP, peak EXP correlations were more consistent across rater pairs, suggesting greater stability in identifying discrete moments of heightened experiencing.

This pattern may reflect the differing judgement demands of the two indices. Peak EXP required raters to identify salient moments of experiential intensity, whereas mode EXP required a broader judgement of the client's prevailing level across the segment. Such global judgements may be more vulnerable to variation in rater interpretation, particularly in mid-therapy sessions where experiencing can fluctuate across brief episodes.

Table 8.1: Summary Table for Spearman Correlation (N, Df, and p-value).

	Mode EXP	Rater 1-Rater 2	Rater 1-Rater 3	Rater 2-Rater 3
(R)	*Coefficient*	0.62**	0.71**	0.53*
	N	17	17	17
	Df	15	15	15
	p value	0.01	0	0.03
	Peak EXP	Rater 1-Rater 2	Rater 1-Rater 3	Rater 2-Rater 3
(R)	*Coefficient*	0.65**	0.64**	0.60**
	N	17	17	17
	Df	15	15	15
	p value	0	0.01	0.01

Note. DF=degree of freedom; N= number of transcriptions; ***: Correlation is significant at the 0.01 level (2-tailed), *: Correlation is significant at the 0.05 level (2-tailed).*

Nevertheless, statistically significant inter-rater correlations, these findings should be interpreted with caution. The inter-rater correlations presented in Table 8.1 were weaker than those found in calibration studies of the EXP Scale, where inter-rater reliability has been reported to range from .76 to .91 (Klein et al., 1986). According to Gisev et al. (2013), interrater reliability indices reflect consistency in relative judgements rather than certainty about the correctness of the ratings themselves. In the present study, EXP ratings were

conducted by raters who were trained in the use of the scale but were not expert developers of the measure. Consequently, although raters demonstrated a shared understanding of the ordering of experiential levels, some degree of imprecision in the assignment of absolute levels cannot be ruled out. This is particularly relevant for peak experiencing, where judgements depend on the identification and interpretation of brief experiential shifts. The observed level of inter-rater reliability therefore supports cautious use of the EXP ratings as indicative of relative differences in experiencing across clients, while also recognising that greater rater expertise or extended calibration may have yielded stronger convergence. Overall, the inter-rater reliability findings were adequate to support subsequent analyses. The next step is to compare scores between mode and peak experiencing.

8.3.2 Comparing Mode and Peak Score

Table 8.2 presents the frequency distribution of peak and mode EXP ratings at Session 10. Peak EXP clustered most strongly at level 3 (n = 20), indicating that half of the sample reached this level as their highest point of experiencing during the session. Levels 2 and 4 were each observed seven times, while level 5 occurred less frequently (n = 6). No peak ratings reached levels 6 or 7.

Mode EXP showed a lower overall distribution. The most common modal level was 2 (n = 16), followed by level 3 (n = 11). Level 1 ratings were observed only for mode (n = 8), consistent with mode reflecting the client's prevailing level of experiencing rather than the highest level briefly attained. Level 4 occurred infrequently (n = 5), and no clients showed a modal level of 5, 6, or 7.

Taken together, these findings indicate that many clients were able to reach level 3 during moments within the session, yet their more typical style of

experiencing remained closer to level 2. This suggests intermittent movement toward greater internal engagement without sustained deeper experiential contact across the session. A smaller subgroup briefly reached level 5, although not consistently enough for this to become their dominant mode of processing.

Table 8.2: Frequency Distribution of Peak and Mode EXP Levels at Session 10

Clients' Peak Level	Frequency	Clients' Mode Level	Frequency
1	0	1	8
2	7	2	16
3	20	3	11
4	7	4	5
5	6	5	0
6	0	6	0
7	0	7	0

Note. EXP= Experiencing Scale; For (n)=40

Across both indices, scores were concentrated between levels 2 and 5, with no observations at levels 6 or 7. This suggests that by mid-therapy the sample largely remained within lower-to-middle levels of experiencing, broadly consistent with Carl Rogers' stages in which internal awareness is emerging but not yet stably integrated. The restricted score range may also have reduced variability and attenuated associations with later outcome variables such as authenticity.

Table 8.3 presents the descriptive statistics for clients' perceptions of the therapist's conditions at Session 5, mode and peak experiencing at Session 10, and authenticity at Session 15, including means, standard deviations, and internal consistency estimates. The mean score for B-LRI at Session 5 suggests that clients generally perceived Rogers' therapeutic relationship positively during

the early phases of therapy. The relatively high standard deviation shows considerable variability in how clients perceived and rated their relationship with their therapists. Moreover, the AS mean score at session 15 shows a moderate increase in authenticity in later session (See Table 7.1).

Table 8.3: Descriptive analysis between B-LRI, AS and EXP across different sessions

	N	Mean	SD	α
B-LRI S5	40	64.18	26.02	0.88
AS S15	40	51.15	12.87	0.85
Peak S10	40	3.3	0.94	0.84
Mode S10	40	2.32	0.94	0.84

Note. AS= Authenticity Scale, B-LRI= Barret-Lennard Relational Inventory, EXP= Experiencing Scale; S5= Session 5, S10= Session 10, S15= Session 15

In contrast, EXP scores at Session 10 indicate that clients' experiential engagement was limited. The mean peak EXP score (M = 3.30) suggests that clients were occasionally able to engage with inner experience at an emerging experiential level, characterised by tentative reflection and partial symbolisation of feelings. However, the lower mean modal EXP score (M = 2.32) indicates that this deeper engagement was not sustained and did not represent clients' dominant way of experiencing during the session. The relatively low standard deviation of EXP indicates less variation in their experience scores than in B-LRI and AS. These findings suggest that although a facilitative relational climate may be present and associated with later movement toward authenticity, experiential engagement may not yet serve as a consistent mechanism by which perceived therapist conditions translate into psychological change. This pattern may indicate that deeper experiential processing requires either more prolonged

exposure to the therapist's conditions or emerges later in the therapeutic process once sufficient safety and trust have been established.

After analysing the descriptive characteristics of the variables, bivariate correlations were conducted to evaluate the relationships between clients' early perceptions of the three therapists' conditions, their mid-therapy experiencing, and their later authenticity levels. These analyses offered an initial assessment of whether EXP met the statistical criteria for mediation.

Table 8.4 compares the strength of associations between clients' perceptions of the therapist's conditions at Session 5 (B-LRI), experiencing at Session 10, and authenticity at Session 15, distinguishing between peak and mode EXP.

Table 8.4. Pearson Correlation between B-LRI, EXP and Authenticity Across Time

Variables	2	3
1. Peak EXP S10	0.2	.31a
2. AS S15	—	.44b
3. BLRI S5	—	—
4. Mode EXP S10	0.1	0.24

Note. AS= Authenticity Scale, B-LRI= Barret-Lennard Relational Inventory, EXP= Experiencing Scale; S5= Session 5, S10= Session 10, S15= Session 15; ap< 0.05, bp<0.01

In relation to the association between earlier relational perception and mid-therapy experiencing, peak EXP at Session 10 showed a small but statistically significant positive association with B-LRI at Session 5 ($r = .31$, $p < .05$). In contrast, the corresponding association for mode EXP was weaker and did not

reach statistical significance (r = .24). This suggests that moments of heightened experiencing relate more closely to clients' early perceptions of the therapist's conditions than clients' typical level of experiencing during the session.

Furthermore, neither peak nor mode EXP demonstrated statistically significant associations with later levels of authenticity. In contrast, AS at Session 15 showed a moderate, statistically significant correlation with B-LRI at Session 5 ($r = .44$, $p < .01$), indicating that clients' early perceptions of the three therapists' conditions were more strongly related to later levels of authenticity than mid-therapy experiencing when examined through correlation. Mode EXP did not demonstrate inferential associations with either B-LRI or AS. Consequently, it was removed from subsequent analyses, and peak EXP was retained as the sole operational indicator of experiencing.

The following analysis used linear and multiple regression models to test whether B-LRI at Session 5 was associated with peak EXP at Session 10 and AS at Session 15.

8.3.2 The Association between early B-LRI, mid- Peak EXP and later Authenticity levels

Table 8.5 displays two separate linear regressions examining the association between clients' perceptions of three therapists' conditions at Session 5 and two outcome variables. The first regression tested the relationship with peak experiencing at Session 10.

First, Table 8.5.a showed that B-LRI at Session 5 significantly predicted clients' experiencing level at Session 10 ($\beta = .31$, $p < 0.05$). This indicates that higher client perceptions of the three therapists' conditions earlier in therapy were associated with a greater capacity to focus inward later in therapy sessions, suggesting that when clients perceive these three conditions, they are better

able to receive and access their inner experience. The model accounted for 10% of the variance in the outcome ($R^2 = .10$), $F(1, 38) = 4.11$, $p < .05$, suggesting a small but statistically significant contribution of the predictor.

Table 8.5a: Linear Regression Analysis to test the predictive effect on B-LRI at Session 5 and EXP at Session 10

		Unstandardised coefficients		Standardised coefficients		95% CI for β		
		B	SE	β	t	Lower	Upper	R^2
1	(constant)	2.58	0.38	0	0	-0.31	0.31	
	B-LRI S5	0.01	0.01	.31a	2.03	0.01	0.62	.1a

Note. B-LRI= Barret Lennard Relational Inventory; S5= Session 5; SE= Standard error, CI= Confidence Interval; ap< 0.05

Second, Table 8.5.b showed that B-LRI at Session 5 significantly predicted clients' authenticity at Session 15 ($\beta = .44$, $p < .01$). This indicates that higher clients' perceptions of the three therapists' conditions earlier in therapy were associated with higher levels of authenticity later in therapy. This suggests that when clients experience the therapeutic relationship as empathic, accepting, and genuine early on, they are more likely over time to move toward greater alignment between their experience and self-concept. The model explained 19% of the variance in authenticity ($R^2 = .19$), $F(1, 38) = 9.11$, $p < .01$.

Table 8.5b: Linear Regression Analysis to test the predictive effect on B-LRI at Session 5 and Authenticity at Session 15

		Unstandardised coefficients		Standardised coefficients		95% CI for β		
		B	SE	β	t	Lower	Upper	R^2
2	(constant)	37.2	4.98	0	0	-0.31	0.31	
	B-LRI S5	.22b	0.07	.44b	3.02	0	0.62	.19b

Note. B-LRI= Barret Lennard Relational Inventory; S5= Session 5; SE= Standard error, CI= Confidence Interval; ap< 0.05

Both linear regression models showed statistically significant associations between clients' perceptions of the therapists' conditions at Session 5 and later scores on experiencing and authenticity, supporting the temporal ordering proposed in Rogers' model. These findings indicate that B-LRI functions as a meaningful predictor of both variables. On this basis, it was appropriate to proceed with a multiple regression to examine the contribution of B-LRI alongside clients' higher levels of authenticity and experiencing.

Table 8.6 shows the impact of clients' Peak experiencing at session 10 and of clients' perceptions of Rogers' three therapist conditions at session 5 on the clients' authenticity level at session 15. In Model 1, the linear regression between EXP at session 10 and authenticity at session 15 was not statistically significant, indicating that the clients' EXP level at session 10 did not contribute to meaningful change in the statistical variance in later clients' authenticity, $F(1,38) = 1.51$, $p = .23$.

In Model 2, the results show a significant relationship between B-LRI at session 5 and their authenticity at session 15 ($\beta = .42$). This shows that for every

one-unit increase in clients' perception of Rogers' three therapists' conditions at session 5, there is an associated 0.42 unit increase in authenticity level at session 15. The R^2 value of .20 shows that clients' perceptions of the three therapists' conditions at Session 5, together with peak EXP at Session 10, explain 20% of the variation in authenticity levels at Session 15, $F(2,37) = 4.54$, $p = .02$

Table 8.6: Regression Analysis to test the Predictive Effect of clients' Earlier EXP and B-LRI levels on Later Authenticity levels

		Unstandardised		Standardised		95% CI for β		
Mode		B	SE	β	t	Lower	Upper	R^2
1	(Constant)	42.3	7.47	0	0	-0.32	0.32	
	EXPS10	2.68	2.18	0.2	1.23	-0.13	0.52	0.04
2	(Constant)	34.91	7.44	0	0	-0.29	0.29	
	B-LRI S5	0.21	0.08	.42b	0.42	-0.25	0.38	.20a
	EXPS10	0.88	2.13	0.64	2.71	0.11	0.73	

Note. N= 40; *AS*= Authenticity Scale, *B-LRI*= Barret-Lennard Relational Inventory, *EXP*= Clients' Experiencing Scale; *S5*= Session 5, *S10*= Session 10; *SE*= Standard error, *CI*= Confidence Interval; *ap*< 0.05, *bp*<0.01

The change in explained variance (ΔR^2) indicated a significant 16% increase from Model 1 to Model 2, showing that clients' earlier perceptions of the three therapists' conditions at Session 5 accounted for an additional 16% of the variance in authenticity at Session 15, $\Delta F(1, 37) = 4.11$, $p = .01$. This indicates that the introduction of B-LRI at Session 5 significantly improved model fit. Although clients' experiences did not reach statistical significance, including it alongside B-LRI helped clarify the relative contribution of relational (B-LRI) and process (EXP) variables over time. These findings support a temporal ordering in which clients' early perceptions of the three therapists' conditions are associated with both subsequent experiencing and later authenticity.

On this basis, the multiple regression results provided an appropriate foundation for the subsequent mediation analysis, which examined whether higher levels of clients' experiencing at Session 10 mediated the relationship between their earlier perceptions of the therapist's three conditions and their later authenticity level. This analysis operationalised Rogers' (1957) proposed relational–process–outcome pathway by estimating the indirect effect of B-LRI on authenticity through EXP.

8.3.3 Mediation Analysis

The results are presented in Table 8.7 with the unstandardised coefficients, which include the effect of the IV on the mediator (denoted as "a"), the unique effect of the mediator on the dependent variable (denoted as "b"), and the indirect effect (denoted as "ab"), which represents the mediation effect. The direct effect of the IV on the dependent variable, excluding the mediator's influence, is also provided (denoted as "c'"). A 95% CI is also reported for the indirect effect, with lower and upper bounds showing the range within which the actual effect is likely to fall.

Table 8.7 shows that the association between B-LRI at Session 5 and EXP at Session 10 was small and non-significant (path *a*: b = .01, 95% CI [−.04, .07]). The association between EXP at Session 10 and authenticity at Session 15 was also non-significant (path *b*: b = .88). Accordingly, the indirect effect was negligible (ab = .01), providing no evidence that experiencing mediated the relationship between therapist conditions and later authenticity.

Table 8.7: Regression Table for Mediation Analysis

Mediator	Unstandardised coefficients				95% CI	
	Effect of IV on mediator (a)	Unique effect of mediator (b)	Indirect effect (ab)	Direct effect (c')	Lower	Upper
EXP S10	0.01	0.88	0.01	.21a	-0.04	0.07

Note. N= 40. All coefficients are unstandardised for paths a, b, ab, c; EXP= Experiencing Scale; S10= Session 10; CI= Confidence Interval, IV= Authenticity

After accounting for EXP, the direct pathway from B-LRI at Session 5 to authenticity at Session 15 (*c'*) remained statistically significant (*b* = .21). This indicates that clients' early perceptions of the therapist's three conditions were associated with later authenticity independently of mid-phase experiencing. The mediation hypothesis was therefore not supported.

This finding does not diminish the relevance of EXP as a process variable. Rather, it highlights the limitations of modelling a developmental and temporally ordered process using linear mediation with observed summation scores. AS was operationalised as a continuous global score, whereas EXP represents an ordinal, level-based process. Treating EXP as a continuous mediator, therefore, risks obscuring how clients' experiencing levels are organised over time. These constraints suggest that the manner in which clients engage with their experience does not operate as a continuous intervening mechanism across its full range. Instead, EXP may function as a threshold-dependent process, such that clients' later authenticity levels are associated with clients reaching particular experiencing levels rather than with incremental increases in experiential depth. This issue is likely to be accentuated in small samples and

points to the need for a more process-sensitive, temporally informed analytic approach. Therefore, it is possible that clients who are more able to adopt an inward, receptive orientation may be better positioned to make use of the three therapists' conditions as therapy unfolds.

Accordingly, the analysis shifted away from testing experiencing as a linear mediator and toward examining whether distinct levels of experiencing were differentially associated with later authenticity. To address this question, an additional objective examined whether clients' peak experiencing levels function as a categorical variable in the temporal relationship between early clients' perceptions of the three therapists' conditions and later authenticity. This approach enabled effects to be examined at specific experiential levels, allowing a more precise assessment of how EXP at Session 10 is positioned in relation to B-LRI at Session 5 and authenticity at Session 15.

8.3.4 The Impact of Different Client EXP Levels on Later Increases in Authenticity

EXP was recoded in RStudio as a categorical predictor within a multiple regression model that included B-LRI and authenticity (AS) as continuous variables. Peak experiencing at Session 10 was first converted into a factor variable (PeakS10F) and subsequently recoded into four categorical levels (PeakS10F2, PeakS10F3, PeakS10F4, and PeakS10F5). This allowed the reference category to rotate across levels, systematically examining differences across models. When Level 2 served as the reference category, Levels 3, 4, and 5 were each compared against it within the same regression model. The reference category was then redefined in subsequent models to allow comparisons involving higher levels of experiencing. This procedure ensured that all meaningful contrasts between experiencing levels were examined. Three

categorical regression models were assessed, yet only the comparison between Level 2 and Level 3 experiencing reached statistical significance. Comparisons involving higher experiencing levels did not reach significance. This indicates that authenticity was higher when clients reached a lower level of experiencing relative to moderate levels, whereas higher experiencing levels did not show additional associations with later authenticity levels.

Table 8.8 reports a multiple regression model in which EXP Level 2 is the reference category; coefficients for Levels 3, 4, and 5 therefore represent differences in authenticity at Session 15 relative to Level 2, controlling for B-LRI at Session 5. Clients rated at Level 3 showed a statistically significant increase of 11.57 units in authenticity at Session 15. This indicates that clients at Level 3 of experiencing were more likely to show higher later authenticity scores than those at Level 2. In contrast higher level 4 or 5 did not show additional explanatory value beyond Level 3. The narrowing of confidence intervals across higher experiencing levels further suggests that, once a moderate level of experiencing is reached, additional depth of experiencing contributes less to explaining variance in later authenticity. In other words, authenticity does not appear to increase incrementally with higher experiencing levels.

In the same model, B-LRI at Session 5 remained a significant predictor of authenticity at Session 15 (B = .22), indicating that early clients' perceptions of the three therapists' conditions exerted an independent influence on later authenticity beyond clients' level of EXP. Together, categorical EXP at Session 10 and B-LRI at Session 5 accounted for 32% of the variance in authenticity at Session 15, $F(4,35) = 4.07$, $p < .001$. This indicates that both relational perception and the manner in which clients engage with their experience contribute to later authenticity, but in different ways.

Table 8.8: Multiple Effects of B-LRI and EXP on Authenticity.

		Unstandardised coefficients			95% CI for B		
Mode		B	SE	t	Lower	Upper	R^2
3	(constant)	29.19b	5.96	4.89	17.08	41.3	
	B-LRI S5	.22b	0.07	3.06	0.08	0.37	.32a
	PeakS10F3	11.57b	4.93	2.35	1.55	21.58	
	PeakS10F4	4.17	6.01	0.69	-8.14	16.49	
	PeakS10F5	7.31	6.5	1.12	-5.89	20.5	

Note. N = 40; *AS* = Authenticity Scale, *B-LRI* = Barret-Lennard Relational Inventory, *EXP* = Experiencing Scale; *S5*= Session 5, *S10*= Session 10; *SE* = Standard error, *CI* = Confidence Interval; *ap*< 0.05, *bp*<0.01; All coefficients are unstandardised for EXP categorical levels: F (level 3, 4 and 5).

Therefore, Table 8.8 indicates that the client's inward focus is a threshold-dependent process, with Level 3 representing a developmentally significant point of engagement relative to later levels of authenticity. However, the categorical nature of the EXP, combined with the continuous structure of the AS, limited the appropriateness of modelling clients' experiencing categorical levels and their authenticity global score together within a CLPD. This mismatch suggests that higher levels of clients' experiencing and their later levels of authenticity unfold through different developmental pathways rather than as parallel continuous processes over time. In contrast, clients' perceptions of the three therapists' conditions showed a clearer temporal link with experiencing. The significant cross-lagged correlation between B-LRI at Session 5 and EXP at Session 10 (r = .31; Table 8.6), therefore, justified further exploration of their temporal relationship (Kenny, 1975). To simplify the CLPD, authenticity was removed, allowing a focused examination of the longitudinal relationship between clients' relational perception and their process levels.

8.3.5 Cross-Lagged Analysis between Early B-LRI and Later EXP

Table 8.9 presents the parameter estimates from a two-wave CLPD examining the temporal relationship between clients' perceptions of the three therapists' conditions (B-LRI) and clients' peak experiencing level (EXP) between Sessions 5 and 10. *Path a* estimates the association between B-LRI at Session 5 and EXP at Session 10 while controlling for EXP at Session 5. *Path b* estimates the reverse association between EXP at Session 5 and B-LRI at Session 10 while controlling for B-LRI at Session 5. *Path c* estimates the stability of clients' perceptions of the three therapists' conditions from Session 5 to Session 10, while *Path d* estimates the stability of experiencing across the same interval. The model also estimates the covariance between B-LRI and EXP at Session 5, as well as the residual covariance between B-LRI and EXP at Session 10, thereby accounting for concurrent associations at each time point. As the two-wave model is just-identified, interpretation focuses on the parameter estimates rather than global fit indices.

The results show that clients' B-LRI scores and their peak experiencing levels exhibited substantial temporal stability. *Path c* indicated that clients' perceptions of the three therapists' conditions at Session 5 strongly predicted their perceptions at Session 10 (β = .83), demonstrating significant continuity in the relational climate. This suggests that a one-unit increase in clients' perceptions at Session 5 is associated with a 0.83-unit increase at Session 10. *Path d* indicated that experiencing also showed significant stability (β = .46), with a one-unit increase in peak experiencing at Session 5 predicting a 0.46-unit increase at Session 10.

After accounting for autoregressive effects, Path a showed a small but statistically significant association between clients' perceptions of the three therapists' conditions at Session 5 and clients' peak experiencing at Session 10 (β

= .01), indicating a modest increase in clients' receptivity to turning their attention inward at the later session. In contrast, *Path b* was not statistically significant, indicating that earlier experiencing was not associated with later perceptions of the three therapists' conditions.

Table 8.9: Temporal Associations Between Client-Perceived Therapist Conditions and Client Experiencing Across Sessions 5 and 10 (N = 40)

Path Diagram	Predictor(s) → Outcome	β	SE	z
Path *a*	$B\text{-}LRI_5 + EXP_5 \rightarrow EXP_{10}$	0.01[a]	0.01	2
Path *b*	$EXP_5 + B\text{-}LRI_5 \rightarrow B\text{-}LRI_{10}$	0.92	2.95	0.31
Path *c*	$B\text{-}LRI_5 \rightarrow B\text{-}LRI_{10}$	0.83[b]	0.1	8.64
Path *d*	$EXP_5 \rightarrow EXP_{10}$	0.46[b]	0.15	3.05
Covariance	$B\text{-}LRI_5 \leftrightarrow EXP_5$	2.13	3.41	0.62
Residual covariance	$B\text{-}LRI_{10} \leftrightarrow EXP_{10}$	0.19	1.95	0.1

Notes. Path a and Path b = Two Cross-lagged Paths; Path c and Path d = Two autoregressive;B-LRI= Barret-Lennard Relational Inventory; EXP= Experiencing Scale; S5= Session 5; S10= Session 10; β=Standardised coefficient; z = Wald test statistic; ap< 0.05, bp<0.01; All EXP values refer to peak levels of experiencing.

Concurrent covariances and residual covariances between clients' perceptions of the three therapists' conditions and experiencing at sessions 5 and 15 were not significant, indicating that the association between the two constructs was not concurrent but primarily expressed through temporal pathways.

Comparison of the two cross-lagged coefficients showed that *Path a* was larger in magnitude than *Path b* (Δb = −0.91). However, this difference was not statistically significant (z = −3.23), indicating that there was no reliable evidence

that the strength of the two directional effects differed. Thus, while the pattern of results favoured the pathway from clients' earlier perceptions of the three therapists' conditions to higher levels of client experiencing, the two cross-lagged effects did not differ meaningfully in magnitude.

8.4 Discussion

The present study examined whether clients' EXP during the middle phase of therapy mediates the relationship between earlier clients' perceptions of the three therapists' conditions and their later levels of authenticity. Contrary to the mediation hypothesis, neither peak nor modal experiencing functioned as a statistically significant linear mediator linking relational perception at Session 5 to authenticity at Session 15. In contrast, clients' early perceptions of the three therapists' conditions showed a consistent and robust association with later levels of authenticity, even after controlling for clients' experiencing.

At a statistical level, the absence of a significant mediation effect is best understood in light of methodological constraints. The ordinal structure of the Experiencing Scale, the restricted range of experiencing observed during mid-therapy, and the modest sample size likely limited the capacity of linear mediation models to detect indirect effects. Treating experiencing as a continuous mediator may therefore have obscured meaningful developmental variation in how clients engage with their experience over time.

Process research supports this interpretation. Pos et al. (2003, 2017) demonstrated that experiential engagement develops in a non-linear, time-sensitive, and inconsistent manner during therapy, often characterised by brief shifts rather than sustained depth. Consistent with this, peak experiencing in the present study showed a stronger connection to earlier clients' perception of the three therapist conditions than modal experiencing, suggesting that brief

moments of inward receptivity are more sensitive to the relational climate than clients' overall level of engagement. Goldman et al. (2005) also noted that peak moments are often linked to earlier therapeutic relationships. These findings imply that peak experiencing may function as a state of readiness or orientation towards inner experience, emerging in discrete windows of relational influence rather than as a linear accumulation over time.

Although peak experiencing is shaped by relational conditions, clients differ in their habitual capacity to attend inwardly to felt experience (Klein et al., 1986), suggesting that EXP also reflects a relatively stable mode of engagement. In this context, peak experiencing captures whether clients can reach a particular level of inward receptivity at any point, whereas modal experiencing reflects the most frequent or typical level across sessions. Because peak experiencing marks the presence or absence of access to a given experiential level, it is better understood as a categorical indicator of readiness that is sensitive to relational factors, whereas modal experiencing averages across variability may obscure brief but developmentally meaningful moments of inward engagement. Together, these results indicate that the three therapist conditions facilitate opportunities for peak experiential engagement, even when a client's typical level of engagement remains unchanged.

At a theoretical level, however, the absence of mediation does not undermine Rogers' formulation of change. Rogers' (1957, 1959) hypothesis is causal in the sense implied by necessity and sufficiency, but this causality is relational and phenomenological rather than linear or mechanistic. Change is proposed to unfold developmentally as clients take up the therapist's conditions over time, rather than through a fixed sequence in which one variable proportionally transmits effects to another. From this perspective, linear mediation constitutes a mismatched test of Rogers' six necessary and sufficient

conditions, as it assumes a form of process transmission that is not central to his account of therapeutic change.

Developmentally, the findings carry clear theoretical meaning. Most clients clustered at level 3 of experiencing, corresponding to stages characterised by tentative internal awareness and early symbolisation. Rogers (1961) described this stage as a critical point at which previously avoided or threatening experiences become accessible to awareness and can be tentatively acknowledged. He proposed that constructive personality change begins not with emotional intensity, but with the client's growing willingness to turn inward toward experience within a climate of acceptance. The clustering of clients at this level suggests that a moderate degree of experiential openness may be sufficient for movement toward authenticity when the therapist's conditions are perceived as present.

This interpretation is reinforced by Zwiercan and Joseph's (2018) account, which emphasised that growth is associated with an inward, accepting, and non-directive orientation toward experience rather than with emotional intensity or deliberate experiential effort. Level 3 experiencing reflects precisely this manner of engagement: experience is tentatively symbolised, held with reduced defensiveness, and approached with receptivity rather than effort. At this level, clients appear sufficiently open to receive and make use of the three therapist's conditions without requiring deeper or more sustained experiential processing. The absence of a linear mediating effect, therefore, does not contradict process-oriented accounts of growth but suggests that experiential receptivity operates as a threshold condition rather than a continuously intensifying pathway.

In contrast, higher levels of experiencing did not predict higher subsequent levels of authenticity. This does not imply that clients operating at levels 4 or 5 lack authenticity. Rather, these levels likely reflect a mode of inward

engagement characterised by sustained access to felt experience, fluid symbolisation, and reduced defensiveness. For such clients, authenticity may already be relatively established and integrated, such that deeper in-session experiential engagement does not translate into higher global levels of authentic functioning at a later time point. In this context, clients' experiencing at levels 4 and 5 may function to maintain or consolidate existing alignment between experience and self-concept rather than to elevate authenticity further. From this perspective, a higher level of experiencing may precede, accompany, or temporarily surpass a higher level in authenticity, especially within a limited observational window. The present findings support a developmental view of client process, where a receptive attitude towards experience is enough to support movement towards congruence.

Temporally, the findings indicate that clients' earlier perceptions of the three therapists' conditions are associated with later levels of experiencing, whereas earlier experiencing is not associated with later relational perception. Although the magnitude of this association is small, the pattern aligns with process-oriented accounts in which experiential openness emerges within a facilitative relational climate (Goldman et al., 2005; Pos et al., 2009), with relational conditions preceding deeper engagement with experience. The findings of the CLPD suggest that clients' perceptions of the three therapists' conditions and their later levels of experiencing do not co-occur synchronously. Experiencing does not necessarily deepen in the same session in which the therapist is perceived as empathic, congruent, or accepting. Rather, the client's perception of the three therapists' conditions appears to operate over time, forming a relational climate that clients gradually internalise and that supports deeper engagement with experience in subsequent sessions. The influence is therefore developmental and delayed rather than immediate or concurrent.

However, other possible reasons for the lack of mediation should still be considered. The limited representation of higher experiencing levels might be due to the sensitivity limits of categorical EXP ratings, a restricted range, or the timing of when experiencing was measured. It is also possible that higher experiencing levels need more relational stability, readiness, or time before they appear in overall measures of authenticity. These factors imply that the current findings should not be viewed as evidence against deeper experiencing itself, but rather as challenging the idea that greater experiential depth always leads to later outcomes. Instead, the findings support a nuanced perspective where a sufficient level of experiential receptivity allows the therapist's conditions to foster further integration, without the need for increased intensity or cultivation of the client's internal process.

A significant limitation to consider is the inter-rater reliability for experiencing, which was acceptable but lower than in initial calibration studies. This decline likely results from methodological differences rather than issues with the construct itself. The primary rater was the only one involved, and her ratings might not accurately reflect the client's experiencing levels. Furthermore, measurement error, restricted range, and the ordinal nature of the Experiencing Scale could have weakened indirect effects and made linear mediation models less appropriate. These limitations imply that experiencing might be better conceptualised as a categorical threshold variable rather than a continuous mediator in person-centred research.

8.5 Conclusion

In conclusion, the present study refines the understanding of how clients engage with their experience in a person-centred therapeutic setting. Experiencing does not appear to operate as a continuous or transmissive

mechanism linking relational conditions to outcomes. Instead, it reflects the client's way of engaging with emotion within a supportive relational climate. Brief moments of inward receptivity may be developmentally meaningful without requiring sustained experiential depth, and moderate levels of experiential engagement may be sufficient for later levels of authenticity. This interpretation maintains the non-directive ethos of PCT and cautions against accounts that implicitly turn experiential engagement into a technique rather than recognising it as an emergent client process.

Mitchell et al. (1977) noted that PCT has been criticised for being insufficiently structured for clients thought to require more directive interventions. This critique has contributed to the development of pluralistic and integrative approaches (Cooper & McLeod, 2011; Crisp, 2022), in which therapists often incorporate experiential techniques from other orientations to facilitate emotional processing. Murphy (2014) and Ong et al. (2020) cautioned that such practices risk departing from Rogers' humanistic principles by shifting the therapist from a relational to a directive role. Rogers (1957, 1961) framed non-directivity not as therapist passivity but as a principled trust in the organism's process, supported by the therapist's conditions.

From this perspective, the assumption that later levels of authenticity require the active intensification of experiencing becomes problematic. The present findings indicate that later levels of authenticity are observed when clients are located at moderate levels of experiencing, particularly Level 3. A receptive, inwardly oriented stance appears sufficient when situated within the client's perception of the three therapists' conditions. The findings suggest that the therapist's role is to provide the relational conditions that enable clients not only to perceive these three conditions but also to turn their attention inward.

These conditions themselves appear sufficient to support clients' engagement with inner experience.

The following chapter synthesises these findings with the broader results of the thesis to evaluate their implications for Rogers' hypothesis of the necessary and sufficient conditions and to reflect on the theoretical, methodological, and clinical contributions of the study.

Chapter 9: *General Discussion and Conclusions*

9.1 Introduction

The chapter summarises the key findings of the thesis and situates them within the core theoretical proposition derived from Rogers' (1957, 1959) six necessary and sufficient conditions for constructive personality change. It shows that clients' perceptions of the three therapists' conditions are positioned earlier in the therapeutic process and are associated with subsequent psychological processes within therapy. Rather than treating this relationship as static or purely correlational, the study conceptualises it as a *directional process hypothesis* unfolding over time, consistent with Rogers' (1961) articulation of therapy as a staged developmental process in which psychological processes are sequentially organised across identifiable phases.

To examine this proposition, an integrated analytic model was developed to represent the six conditions within a dynamic therapeutic process. A series of interconnected analyses—including principal components, correlations, regressions, cross-lagged, and mediation—were used to examine *temporal ordering and directionality* across the early, middle, and later phases of therapy. This approach reflects Rogers' (1961) conceptualisation of therapy as a staged process and enabled assessment of directional pathways without treating personality change itself as the object of analysis. In line with Rogers' formulation, omission of any one condition implies that the hypothesis itself is not being tested. Treating the six conditions as an inseparable set clarified their logical status and addressed longstanding questions concerning their necessity and sufficiency.

Importantly, probabilistic findings are interpreted within a logically structured theoretical framework. By distinguishing causal sufficiency from deterministic implication, the study offers a rigorous means of evaluating the *directional logic* of strong theoretical claims in psychotherapy without reducing them to outcome-based or purely associative explanations. This strengthens the connection between formal theory and empirical testing.

The chapter then turns to the theoretical and methodological implications of these findings. The contribution is assessed in terms of how the six necessary and sufficient conditions can be operationalised, measured, and examined within longitudinal designs that prioritise temporal ordering. The thesis's limitations are subsequently acknowledged, including issues related to sample size, the use of secondary analysis, measurement constraints, and the operationalisation of process variables. In particular, reliance on an existing dataset restricted control over the timing and structure of measurement, while the rating of clients' experiencing (EXP) necessarily involved interpretative judgement when translating moment-to-moment therapeutic material into ordinal process levels. Recognising these constraints allows for careful interpretation and prevents overgeneralisation. The chapter concludes by outlining directions for future research, emphasising further refinement of longitudinal designs, improved modelling of process variables, and continued examination of directional pathways through which the quality of the therapeutic relationship, in interaction with client-related factors, may be organised over time.

9.2 Key Findings

Rogers' (1957, 1959, 1961) hypothesis states that psychological contact and client incongruence are followed by the client's perception of the therapist's empathy, congruence, and unconditional positive regard, which, in turn, enable

internal psychological processes that support constructive personality development. The present study examined this sequence at the level of direction, focusing on whether the relational segment of the six conditions, as measured by the Barrett-Lennard Relationship Inventory (B-LRI), temporally precedes later indicators of client development. The systematic review of studies using the B-LRI revealed that much of the current research does not fully adhere to Rogers' (1957, 1959) original hypothesis. Studies vary widely in design, including cross-sectional, analogue, and longitudinal studies; in measurement, using different versions of the B-LRI, item removal, or alternative scoring procedures; and in outcome focus, with many prioritising symptom reductions rather than constructs such as congruence or optimal functioning. These issues mean that the existing B-LRI studies do not constitute a single, coherent body of evidence on which to base reliable cumulative conclusions about Rogers' six necessary and sufficient conditions hypothesis.

A key source of this heterogeneity is the way Condition 4 has been addressed in research. To simplify or modify the B-LRI measure, some researchers removed items assessing unconditionality while retaining those reflecting the level of regard, thereby altering the original construct. These modifications reveal a limitation of the B-LRI instrument but also mark a departure from Rogers' original theoretical framework. These studies mainly attempted to assess the six conditions, but they often fail to examine all aspects of the relational framework, as unconditional positive regard is only partially evaluated in their research designs. Consequently, integrating findings from Rogers' hypotheses is difficult. This is because meta-analyses combine results from non-equivalent constructs and methodologies, potentially producing misleading overall effect sizes.

Overall, these issues mean that many conclusions about sufficiency are based on studies that neither uphold construct integrity nor establish a clear temporal order, complicating the differentiation between relational effects and stability in client functioning. This has significant implications for the present thesis, as it suggests that the fragmented testing of the six necessary and sufficient conditions limits the conclusions that can be drawn from the existing literature. In the absence of integrated tests of the full proposition, Rogers' hypothesis cannot be meaningfully confirmed or refuted. Therefore, the existing literature has rarely tested Rogers' six necessary and sufficient conditions as a unified, temporally ordered hypothesis, neglecting the client- and process-related conditions that complete the theoretical sequence. In particular, the absence of integrated tests of the full proposition raises questions about what it would mean, in empirical terms, to confirm or refute Rogers' hypothesis

To interpret these findings appropriately, it is necessary to situate them in relation to Rogers's original formulation of necessity and sufficiency. From a logical standpoint, four outcomes may follow from empirical evaluation when testing the six necessary and sufficient conditions for temporal direction toward later constructive personality development. The strongest outcome would be full confirmation, in which the six conditions are both necessary and sufficient, such that constructive personality change never occurs without them and always occurs when they are present. This outcome would require deterministic evidence and is therefore implausible within the context of psychotherapy research. Alternative possibilities include the conditions being necessary but not sufficient, sufficient but not necessary, or neither necessary nor sufficient, each of which carries distinct theoretical implications.

However, demonstrating necessity would require showing that constructive personality change does not occur in the absence of client-

perceived therapist conditions. As conceptualised by Dul (2024), necessity causation entails a "bottleneck effect," whereby an outcome cannot occur without a specific condition. Such claims cannot be evaluated within ethical, observational longitudinal designs, which estimate probabilistic associations rather than logical exclusion. Methods capable of testing necessity directly would therefore require unethical deprivation designs or levels of experimental control that are infeasible in psychotherapy research. Thus, the challenge of empirically adjudicating necessity reflects not a weakness in Rogers's theory but a mismatch between the logical strength of the original claim and the type of knowledge that ethical psychotherapy research can generate.

While the formulation of "necessary and sufficient conditions" sets a demanding empirical standard, it does not invalidate empirical testing. Rather, it requires that findings be interpreted with conceptual precision. Rogers did not specify expected time lags, threshold effects, or probabilistic boundaries, all of which become salient when the theory is examined longitudinally. Treating necessity and sufficiency as an inseparable joint claim has therefore tended to obscure partial empirical support in the literature, as findings that address one component but not the other are often interpreted in all-or-nothing terms, either as wholesale confirmations or rejections of the hypothesis. The present findings clearly illustrate this difficulty: while the six conditions can be understood as constituting a probabilistic sufficient pathway toward authenticity, their necessity cannot be empirically evaluated within the present design.

Concurrently, the findings refine rather than oversimplify Rogers' sufficiency claim. When controlling for clients' earlier levels of authenticity, the direct predictive impact of clients' perceptions of the three therapists' conditions on subsequent authenticity levels was diminished. This suggests that later authenticity develops along the trajectory of the client's prior authenticity level

rather than occurring independently. Earlier authenticity contributes significantly to later authenticity, acting as a mediating developmental pathway through which the influence of clients' early perceptions of the three therapist's conditions is sustained over time. Within the six condition clients' early perceptions of the therapist's relational attitudes contribute to this trajectory by enabling and supporting subsequent psychological processes, rather than acting as isolated causal triggers. In this sense, earlier authenticity operates as a developmental pathway through which the influence of early relational perceptions is carried forward over time. These findings suggest that sufficiency in Rogers' framework is best understood not as an immediate or deterministic cause of change, but as the *ongoing adequacy of relational conditions* that orient development in a particular direction, allowing authenticity to unfold probabilistically over time.

The findings also show that clients' early perceptions of the three therapist conditions at session 5 are associated with later levels of authenticity at session 15, consistent with Rogers' proposed ordering of the six conditions. Importantly, this association was not reciprocal: early authenticity did not reliably predict later perceptions of the therapist's conditions. This asymmetry supports the directional logic of the six necessary and sufficient conditions. The findings showed that the six conditions constitute a set of relational and psychological conditions *established early in the therapeutic encounter*, creating the facilitative climate under which probabilistically later levels of authenticity may unfold over time.

Additionally, the role of clients' peak experiencing levels further clarifies the pathway proposed by Rogers. Although experiencing was explicitly examined as a process variable reflecting the client's manner of receiving and engaging with the six conditions, EXP did not function as a statistical mediator between

early perceptions of the therapist's conditions and later authenticity. These finding challenges simplified interpretations of Rogers' model that assume a linear progression in which relational conditions directly generate increasingly intense emotional processing, which in turn produces later developmental outcomes. Instead, the results indicate that experiencing functions as a process indicator of how the therapist's relational conditions are taken up by the client, rather than as a mechanism whose effects increase with greater intensity.

Categorical analyses showed that higher peak levels of experiencing during the mid phase of therapy were not associated with higher later levels of authenticity. Rather, clients who reached a moderate level of peak experiencing were more likely to show later authenticity than those who remained at lower levels. This suggests that authenticity does not depend on progressively deeper or more intense experiencing but may emerge once a sufficient level of experiential engagement has been achieved. More specifically, the findings suggest that while the therapist's relational conditions initiate the directional pathway specified in the six-condition framework, the level of client experiencing required to support movement toward authenticity may be lower than is sometimes assumed. Experiencing does not appear to operate as a maximising mechanism in which progressively higher levels confer additional developmental benefit. Instead, the results indicate that a sufficient level of experiential engagement may be adequate to support later authenticity, once the relational conditions are in place.

Importantly, clients' early perceptions of the three therapists' conditions preceded peak levels of experiencing during the mid phase of therapy. This temporal ordering supports the view that clients' perceptions of the relational conditions are sufficient to support the manner of experiencing required for later developmental movement. Higher levels of experiencing do not appear to confer

additional benefit for authenticity, indicating that the pathway from relational conditions to authenticity operates through sufficient, rather than maximal, experiential engagement. Therefore, across analyses, early perceptions of the three therapists' conditions consistently emerged as the most informative time point, showing stronger associations with mid-phase experiencing and later authenticity than perceptions formed later in therapy.

In summary, these findings demonstrate that Rogers' hypothesis is neither unsupported nor straightforwardly confirmed. Rather, the present study shows that the six conditions can be empirically supported as facilitative and developmentally influential only when examined using client-perceived measures, longitudinal designs, controls for autoregressive stability, and outcomes that index congruence, alienation and accepting external influences. In doing so, the study both supports key aspects of Rogers' theory and refines the understanding of sufficiency in contemporary psychotherapy research. The findings indicate that Rogers's hypothesis of the six conditions, as initially formulated in terms of necessity and sufficiency, does not map straightforwardly onto the forms of empirical testing available in psychotherapy research and may therefore require reformulation. From this perspective, the enduring value of Rogers's theory lies not in the literal confirmation of a joint necessary-and-sufficient claim, but in the capacity of its core relational propositions to be examined within contemporary longitudinal designs. Interpreting the key findings, therefore, requires situating them within this epistemic difference, rather than treating the hypothesis as one that can be directly confirmed or rejected through conventional empirical testing.

9.3 Key Implications

9.3.1 Theoretical and Clinical Implications

The findings refine Rogers' hypothesis by shifting the theoretical debate away from whether the conditions are necessary and towards how they sufficiently operate within a developmental process unfolding over time. Sufficiency appears to reside at the level of early relational perception, rather than in a single, invariant mechanism of change. The absence of a universal mediating role for experiencing does not weaken the theory; somewhat, it clarifies that relational conditions may initiate change through multiple downstream pathways.

Considered alongside the broader person-centred literature, these findings are consistent with Rogers' own acknowledgement that the facilitative conditions do not operate uniformly across all clients or therapeutic contexts. Rather than assuming universal effectiveness, Rogers emphasised the importance of understanding the variables that shape when, and for whom, the therapeutic relationship becomes facilitative. At the core of PCT lies the actualising tendency, with change understood as arising primarily from the client's inherent movement towards growth, rather than from the three therapists' conditions alone. Bozarth (1998) similarly emphasised that individuals naturally move towards growth, fulfilment, and the realisation of their potential. In this context, Bozarth et al. (2002) further noted that client factors account for a substantial proportion of therapeutic outcomes, while the three therapist's conditions exert a more limited influence.

Historical findings from the Wisconsin Project echo this position, demonstrating that a non-directive approach posed challenges when working with clients experiencing severe psychological disturbance. Cognitive and

perceptual difficulties were found to limit clients' capacity to perceive and utilise the therapist's relational conditions, thereby constraining therapeutic progress. These findings highlight that the effectiveness of the necessary and sufficient conditions depends not only on their presence but also on the client's capacity to perceive, engage with, and integrate them within the therapeutic process.

Subsequent psychotherapy research has highlighted the role of client characteristics and process variables in shaping responsiveness to relational conditions (e.g: Lambert & Barley, 2001). Empirical work has shown, for example, that perfectionistic clients often experience greater difficulty forming a strong therapeutic alliance and tend to show poorer outcomes (Zuroff et al., 2000). At the same time, the identification of experiencing as a threshold-dependent process carries important clinical implications. Clients who do not reach a minimum level of experiential engagement may not show subsequent gains in authenticity, despite the presence of relational conditions. This does not imply a need for directive techniques but rather invites therapists to remain sensitive to the client's readiness and capacity for experiential engagement, pacing the therapeutic process accordingly. Clients who reached level 3 of experiencing during the mid-phase of therapy showed later levels of authenticity at the end of therapy than those remaining at level 2. This suggests that a moderate degree of emotional engagement may reflect a readiness that enables clients to make effective use of the therapist's empathy, congruence, and unconditional positive regard.

The findings indicate that outcome limitations are not due to a lack of techniques, but rather to how relational conditions are perceived and present during therapy. They suggest that relational sufficiency accommodates individual differences in client engagement and internalisation of the therapeutic relationship. From a person-centred view, this underscores the importance of

trusting the client's process and recognising that growth can happen through various experiential pathways. The results suggest that the six necessary and sufficient conditions are effective not during very high levels of experience, but when clients participate in moderate, brief, yet intense experiential exposure. This does not contradict Rogers' hypothesis but refines its application by emphasising that the client's experiencing acts as a variable that influences when and how relational conditions facilitate change.

From a clinical standpoint, these findings caution against expecting immediate or straightforward shifts in authenticity levels following the establishment of a facilitative climate. Consistent with prior research, early relational quality appears to support engagement and lay the groundwork for internal processes, rather than producing rapid outcome change (Elkin et al., 2014; Bayliss-Conway et al., 2021). In training and clinical practice, the absence of early visible shifts in authenticity levels should not be interpreted as therapeutic failure. Early sessions often serve to establish the relational and experiential conditions necessary for later levels of authenticity to emerge.

9.3.2 Methodological Implications

Methodologically, this study advances the literature by being the first to operationalise all six of Rogers' necessary and sufficient conditions within a longitudinal, temporally ordered pathway. A central implication concerns how Rogers' hypothesis is defined and tested empirically. Studies that isolate selected elements of the therapeutic relationship, or that model single associations without specifying the full relational–experiential–developmental sequence, cannot reasonably claim to test Rogers' hypothesis. Rogers did not present the six conditions as independent predictors or interchangeable components. Rather, he described an integrated configuration in which psychological contact and

client incongruence are present, the therapist offers empathy, unconditional positive regard, and congruence, these conditions are perceived by the client, and this perception is taken up experientially and reflected in the client's manner of relating to self.

The use of client-reported measures, particularly the B-LRI and the AS, therefore, represents a critical methodological shift. This approach allows examination of whether the therapist's conditions are perceived by the client in terms of psychological contact and incongruence, rather than being assumed or inferred from observer ratings. It also allows the six conditions to be examined in relation to the organisation of the client's self-experience over time, rather than being reduced to symptom-based outcomes. In doing so, the study aligns more closely with Rogers' original formulation, which conceptualised the six conditions as a relationally mediated process unfolding through time, rather than as discrete causes producing measurable change.

However, the current study indicates that significant methodological challenges remain, especially regarding Condition 4. A model that excludes unconditional positive regard or condenses outcomes into a single endpoint might be internally consistent from a psychometric perspective, but no longer reflects Rogers' description of the six necessary and sufficient conditions. These findings indicate that current methodologies remain some distance from fully operationalising Rogers' hypothesis as a logically integrated system. While the shift to client-reported measures represents a necessary advance in addressing Condition 6, it is insufficient if Condition 4 is only partially represented or implicitly excluded in measurement models. Methodological development must therefore move beyond psychometric optimisation alone and engage more explicitly with how unconditional positive regard is conceptualised, operationalised, and retained within relational measures. One promising

direction involves the use of integrative approaches, such as the mini-B-LRI proposed by Chen et al. (2021), which preserves representation of all relational components rather than selectively removing unconditionality items. Without such alignment, empirical tests risk becoming internally coherent yet theoretically incomplete, limiting their capacity to evaluate Rogers' six necessary and sufficient conditions as initially proposed.

9.4 Limitations

Testing Rogers's proposed relational–process–outcome pathway within a naturalistic psychotherapy dataset necessarily involved a series of methodological trade-offs. Although the study was designed to preserve theoretical fidelity and analytic rigour, several limitations place clear boundaries on the strength, scope, and interpretation of the findings. These limitations reflect both structural constraints inherent to longitudinal psychotherapy research and design-specific restrictions arising from the available data and analytic tools. They are outlined here to clarify the conditions under which the findings should be interpreted and to identify areas where future research could strengthen causal and temporal inference.

9.4.1 Sample Size

The relatively small longitudinal sample available for analysis imposes important constraints on the extent to which Rogers' six necessary and sufficient conditions can be tested empirically. The primary analytic sample (N = 40) limited statistical power, particularly for detecting small but theoretically meaningful cross-lagged effects, and increased sensitivity to sampling variability. As a result, parameter estimates were more susceptible to instability, and model convergence was more fragile than would be expected in a larger sample.

This limitation is especially salient for cross-lagged panel modelling, which is central to evaluating Rogers' hypothesis that the therapist's conditions temporally precede and facilitate client change. Robust tests of this claim require reliable separation of autoregressive stability from cross-lagged influence. With a modest sample size, observed directional paths should therefore be interpreted as *probabilistic indications of temporal ordering* rather than as definitive evidence of causal precedence or sufficiency. Although the findings are broadly consistent with Rogers' proposed sequence of relational conditions leading to experiential process and subsequent authenticity, the magnitude and consistency of these effects cannot be assumed to be stable or generalisable.

9.4.2 Self-Reported Measurement Tools

A further limitation of the present study concerns the reliance on standardised instrumental tools to examine Rogers' six necessary and sufficient conditions for constructive personality change. Although the study was designed to examine the temporal implications of Rogers' framework, the six conditions cannot be directly observed or exhaustively operationalised and therefore required translation into measurable proxies. Conditions 1 and 2—psychological contact and client incongruence—were treated as prerequisite assumptions rather than directly measured variables. Conditions 3 to 6 were represented through client self-report of perceived therapist attitudes, using established relational measures designed to capture the enduring relational climate rather than moment-to-moment therapeutic process. Constructive personality change, which Rogers described as movement toward greater congruence and openness to experience, was operationalised at the outcome level through self-reported authenticity, reflecting reduced alienation and accepting external influences and increased alignment between experience and self-concept across time.

This form of instrumentalisation necessarily constrains the interpretation of the results. Rogers conceptualised personality change as a holistic, organismic, and experiential process involving shifts in awareness, valuation, and self-structure that unfold within the therapeutic encounter. Standardised self-report measures do not capture this lived process directly, but instead index selected dimensions of experience at discrete time points. As a result, the observed findings reflect associations between measured representations of Rogers' constructs rather than direct evidence of the conditions as enacted moment-to-moment or as jointly sufficient causal mechanisms in practice.

Reliance on self-report measures for both relational predictors and outcome variables also introduces the risk of common method bias, which may inflate observed associations (Podsakoff et al., 2003). When theoretically distinct constructs are assessed through the same methodological channel, correlations may partly reflect shared evaluative or appraisal processes rather than substantive relational effects. As demonstrated in classic work on construct validity (Campbell & Fiske, 1959), this limitation is particularly salient when evaluating a theory that explicitly distinguishes relational conditions from outcome change, as does Rogers' model.

This reliance on self-report and instrumental measurement suggests that the results primarily reflect associations between clients' reported perceptions of the quality of the therapeutic relationship and their retrospective self-evaluations over time. As both relational predictors and outcome variables were assessed through the same methodological channel, the observed relationships may be inflated by shared response tendencies or evaluative processes rather than representing fully distinct relational inputs and outcomes. Consequently, the findings should be interpreted as probabilistic rather than direct evidence of

enacted therapist conditions or organismic change, and caution is warranted when inferring causal specificity from these associations.

9.4.3 Retrospective Design Limitation

A further methodological limitation arises from the use of secondary analysis. The Human Flourishing Project (HFP) provides a uniquely rich, naturalistic, and longitudinal clinical dataset, offering rare access to routine psychotherapy conducted within a research-informed training clinic. This context constitutes a major strength of the present study, as it enables examination of Rogers' six necessary and sufficient conditions within real therapeutic practice rather than under artificial or highly standardised experimental conditions.

At the same time, the retrospective nature of the dataset necessarily constrained control over data generation. Because the data had already been collected, it was not possible to standardise therapeutic procedures, regulate the precise timing of measurement occasions, or ensure consistent adherence to protocol across cases. These limitations are particularly relevant when evaluating Rogers' hypothesis, which specifies not only the presence of the therapist's conditions but their consistent psychological availability and effectiveness over time.

Practical constraints associated with routine clinical data further limited the completeness of the analytic sample. Clients completed different versions of the B-LRI across sessions; some audio recordings were missing, and adherence to HFP procedures varied across cases. These issues could not be corrected retrospectively. In addition, patterns of missingness may not have been random. Clients with complete longitudinal self-report and audio data may differ in meaningful ways from those excluded, limiting the representativeness of the observed relational–experiential–developmental sequence.

Variability in therapist compliance, session documentation, or therapeutic delivery may also have influenced the observed associations. Such sources of heterogeneity are difficult to disentangle post hoc and may obscure the degree to which the therapist's conditions were reliably present, mutually realised, or sustained across sessions. Although strict inclusion criteria and extensive data screening were applied to strengthen internal validity, these procedures cannot eliminate unobserved biases inherent in retrospective analysis.

Crucially, because the data were not generated under prospectively controlled or experimental conditions, the study is limited in its capacity to establish causal claims. This constraint is central when considering Rogers' claim of sufficiency. The findings indicate whether observed temporal patterns are consistent with Rogers' proposed relational–experiential sequence, but they cannot demonstrate that the therapist's conditions were the sole or determining cause of later level of authenticity.

Finally, the retrospective design prevented the inclusion of additional measures that could have strengthened the operationalisation of the six necessary and sufficient conditions. It was not possible to incorporate complementary observational or therapist-rated instruments that might have captured the enactment, mutuality, or depth of the therapist's conditions more directly. In addition, relevant contextual variables, such as therapist characteristics (e.g., age, ethnicity or gender), were not collected, further limiting the capacity to examine how therapist-related factors may have shaped the delivery and perception of the therapist's conditions.

9.4.4 Methodological Limitation

A key methodological implication of this study concerns the challenge of identifying analytic models capable of integrating all six conditions, multiple

variables across time, and remaining faithful to Rogers' (1961) stages of process. Cross-lagged panel design and mediation analysis offered valuable frameworks for addressing this challenge, as they enabled the examination of relational, experiential, and self-organisational variables within a single longitudinal model and imposed temporal ordering across phases of therapy. In this respect, these approaches represent an important methodological advance, allowing the six necessary and sufficient conditions to be examined together rather than as isolated or static associations. At the same time, the present findings indicate that such models are only partially congruent with Rogers' original formulation.

More fundamentally, CLPD does not test Rogers' directional hypothesis in a theory-isomorphic form. Rogers' six necessary and sufficient conditions propose a conceptually ordered process in which clients' early perceptions of the therapist's conditions precede and facilitate later levels of authenticity. By contrast, CLPDs are designed to estimate reciprocal cross-lagged paths, including a reverse pathway in which earlier authenticity predicts later perceptions of the three therapists' conditions. This reverse direction is not theoretically anticipated within Rogers' framework, where authenticity is not an antecedent of perceived therapist attitudes but a consequence of the relational climate. As a result, CLPD evaluates directionality within a structurally bidirectional model that does not fully correspond to Rogers' unidirectional theoretical sequence. Evidence consistent with Rogers' hypothesis can therefore only be inferred indirectly, by demonstrating that the pathway from perceived therapist conditions to later authenticity is stronger than, or remains significant alongside, a reverse pathway that the theory itself does not meaningfully propose. In this sense, CLPD tests relative temporal precedence rather than the directional necessity implied by Rogers' model.

When applied to Rogers' six necessary and sufficient conditions, CLPDs also constrain how the hypothesis can be operationalised. Rogers' formulation implicitly assumes that clients enter therapy in a state of incongruence (Condition 2) and move toward greater congruence and authenticity through engagement with the therapeutic relationship. However, the CLPD does not model such developmental movement. In the present study, authenticity scores were reverse-scored to index levels of authenticity rather than alienation and accepting external influences, so the analysis does not reflect a transition from alienation to authenticity within individuals over time. Instead, the model controls for prior levels of authenticity and estimates whether clients' earlier perceptions of the three therapist's conditions temporally precede later levels of authenticity at the group level. As noted by Hertzog and Nesselroade (1987), such models capture interindividual patterns of temporal ordering while obscuring intraindividual developmental shifts.

Hamaker et al. (2015) argued that CLPD may yield misleading conclusions when stable trait-like differences between individuals are not separated from within-person change processes. In such cases, cross-lagged parameters may reflect between-person stability rather than genuine intraindividual influence across time. Consequently, the present analysis does not test constructive personality change in Rogers' original sense, but rather examines whether the therapist's conditions are directionally associated with later indices of authenticity, reframing the hypothesis as a directional pathway of constructive growth rather than as a test of movement from alienation to authenticity.

Measurement decisions introduced further constraints. To preserve theoretical fidelity, the B-LRI and AS were treated as continuous observed variables using full-scale sum scores. This approach avoided fragmenting constructs that are theorised as unified relational and developmental

phenomena within Rogers' framework. However, it also reduced analytic flexibility and limited the extent to which latent structure could be modelled. In the factor analyses, it would have been possible to aggregate only those B-LRI items that demonstrated acceptable loadings, excluding the 10 items reported in Table 10.B in Appendix 10. Such an approach may have reduced noise and granularity measurement, particularly given that modelling a latent construct with approximately 40 indicators places heavy demands on sample size and model stability.

In this sense, the decision to retain all items prioritised conceptual completeness over parsimony, but at the cost of potentially obscuring a more stable latent representation of the quality of the therapeutic relationship within CLPD. Factor analysis presupposes the estimation of latent variables, whereas the use of global observed scores constrains the capacity to examine substructure within the construct when carried forward into the CLPD. When global scores are retained, individual subscales cannot easily be used to represent the total therapeutic relationship or overall authenticity without reintroducing conceptual fragmentation. Treating authenticity as a single observed construct may therefore mask heterogeneity in how different aspects of self-experience unfold over time; while disaggregating it risks misrepresenting Rogers' integrative formulation.

In addition, specifying a just-identified CLPD using observed variables precluded evaluation through global model-fit indices. Interpretation therefore relied on parameter estimates and temporal ordering rather than formal comparison of alternative structural representations of Rogers' theory. Taken together, these decisions reflect an unavoidable trade-off between theoretical coherence and statistical flexibility, highlighting the challenges of

operationalising process-based humanistic constructs within longitudinal quantitative models.

Similar constraints apply to mediation analysis. Rogers' six necessary and sufficient conditions do not imply a mediated causal chain in which experiencing functions as a discrete intermediary mechanism. Rather, Rogers described a relational configuration within which experiencing and self-organisation unfold together in the presence of the full set of conditions. From this perspective, mediation models risk imposing a mechanistic, variable-centred logic onto a theory that is fundamentally processual, client-led, and non-linear. The limited mediating role of experiencing observed in this study therefore reflects not a limitation of Rogers' formulation, but the constraints of applying mediation logic to a relational developmental process.

In summary, the analytic models used in this study were appropriate for examining whether clients' perceptions of the three therapists' conditions temporally preceded later levels of authenticity in a manner consistent with Rogers' proposed sequence. However, they were not suited to testing the sufficiency or completeness of the six necessary and sufficient conditions as a causal change. The findings should therefore be interpreted as supporting the directional plausibility of Rogers' hypothesis in probabilistic terms, rather than as definitive or confirmatory tests of the six conditions as a fully specified process of constructive personality development.

9.4.5 Measurement of Experiencing

This section outlines limitations associated with the measurement of EXP that have direct implications for testing Rogers' six necessary and sufficient conditions. Within Rogers' framework, experiencing is a central process through which the perception of the three therapists' conditions is taken up by the client

and translated into constructive personality change. Limitations in the operationalisation, stability, and temporal representativeness of EXP therefore constrain the extent to which the relational–process–outcome pathway proposed by Rogers can be evaluated.

A key limitation concerns the measurement of EXP as the central process variable. An inter-rater reliability test was conducted at the outset of the coding process with the supervisor to support calibration, yielding moderate agreement (approximately .60). While this level of agreement is generally acceptable for initial calibration, it indicates limited precision and suggests that the full range and variability of clients' experiential engagement may not have been consistently captured. EXP ratings were derived from short, predefined audio segments recorded under naturalistic conditions within a training clinic. This context may have constrained therapist and client behaviour and introduced additional situational variability into the rating process. Following initial calibration, all EXP ratings were completed by a single rater, and no further reliability checks were conducted after coding was completed. Given the prolonged and cognitively demanding nature of EXP rating, this design raises the possibility of rater drift, whereby coding criteria may be applied inconsistently over time due to fatigue, increasing familiarity, or shifting internal benchmarks. Without follow-up or endpoint reliability assessment, it is not possible to determine whether the interpretive framework established during calibration was consistently maintained throughout the coding process. Accordingly, while EXP provided a theoretically coherent and methodologically defensible indicator of client process aligned with the study's primary research question, limitations in reliability monitoring constrain confidence in the temporal stability of EXP ratings. This, in turn, limits the precision with which experiential process can be

linked to the relational conditions specified by Rogers' six necessary and sufficient conditions for constructive growth.

Another key limitation further concerns the operationalisation of client experiencing using both peak and mode EXP scores and the degree to which these indices could be reliably rated under the present coding conditions. Although both indices were derived from the same audio segments, they capture different aspects of experiential process and do not demonstrate equivalent stability at the level of rater judgement. Initial calibration showed more consistent agreement for peak EXP than for mode EXP, suggesting that discrete moments of heightened experiential intensity were easier to identify reliably than the client's prevailing level of experiencing across a segment.

As a result, the inclusion of both indices introduced differential measurement precision into the analysis. Peak EXP captured momentary experiential engagement but did not reflect sustained processing across sessions. Mode EXP was intended to index ongoing experiential engagement but proved less stable when reliant on a single rater's global judgements under naturalistic and time-constrained conditions. Mode ratings required the rater to integrate fluctuations in focus, pauses, emotional depth, and narrative structure across a segment. These integrative judgements were particularly susceptible to interruptions, variation in session length, conversational shifts, and differences between reflective and narrative speech, rendering mode EXP more vulnerable to subjectivity and rater-dependent interpretation. This discrepancy between peak and mode EXP therefore reflects limitations in rating reliability rather than in the theoretical construct of experiencing itself. The resulting measurement error is likely to have attenuated observed associations, particularly in longitudinal and mediation analyses that depend on stable estimation of process variables over time. Reduced consistency in mode EXP ratings may thus have

limited sensitivity to detect experiencing as a mediating process within Rogers' hypothesised relational–process–outcome sequence.

Further constraints arose from the timing and structure of data collection within sessions, which has implications for assumptions underlying CLPD. EXP ratings were conducted on the same days clients completed session forms, reducing available therapy time and often compressing opportunities for sustained inward focus. Although sessions were scheduled for 50 minutes, those selected for analysis (Sessions 1, 5, 10, 15, and 20) were frequently shorter due to administrative demands, with some sessions lasting approximately 40 minutes, others 30 minutes, and some as little as 18 minutes. These reductions limited the feasibility of identifying a consistent 7-minute segment within the first 30 minutes of therapy.

As a result, EXP segments were often drawn from later portions of sessions, when clients were more likely to be transitioning toward closure rather than engaging in deeper experiential exploration. In several late-session recordings, clients appeared aware that the session was nearing its end and shifted toward practical or narrative content, with reduced emotional engagement. By contrast, when clients were unaware of the impending ending, their manner of experiencing appeared less constrained. This pattern suggests that EXP ratings were influenced by session structure and timing rather than reflecting stable experiential functioning.

Contextual disturbances further compounded these timing constraints. For example, in Session 10 of Client 189, the client left the room abruptly, resulting in two separate audio files. The segment prior to the interruption was characterised by level 3 experiencing, whereas the segment following the client's return was marked by level 1 experiencing, dominated by factual narration. This abrupt shift may reflect a genuine disruption in experiential engagement and

increased defensiveness, rather than a stable change in the client's experiential capacity. As a result, the client's overall experiencing rating for the session dropped from level 3 to level 1. Had the therapist continued the recording through the interruption, the relational context of what was occurring may have been captured more fully, allowing greater interpretive clarity regarding the nature of this shift.

Additional procedural challenges arose from recording conditions. In some cases, audio recordings were fragmented or terminated prematurely due to technical issues. For instance, in Session 10 of Client 277, the recording ended before the session concluded, requiring the rater to infer experiential context from preceding material. Such instances necessitated interpretive judgment beyond the recorded data and introduced further non-random variability into the coding process. Therefore, this variability is not random measurement error. EXP ratings were systematically affected by session length, administrative timing, and contextual disturbance, meaning fluctuations in experiencing may not average out across cases. This poses a particular challenge for CLPD, which assumes synchronicity of measurement and relative stationarity of relationships across time points. In a constrained longitudinal sample, these distortions limit confidence in the stability and representativeness of EXP as a process variable within Rogers' proposed pathway.

Additionally, clients' expressive style represents a contextual factor that may shape how experiential engagement is manifested and recognised within therapy. Stiles et al. (1979) found that higher levels of client experiencing were associated with greater personal disclosure, suggesting that emotional exploration becomes more externally articulated when the therapeutic relationship is perceived as safe and responsive. From the perspective of Rogers' six necessary and sufficient conditions, this raises important questions about

how the therapist's conditions are translated into observable experiencing across different communicative styles. In the present study, this issue became apparent during the inter-reliability process.

Appendix 12 presents two seven-minute transcription segments taken from the first 30 minutes of therapy. In Transcription # 1, the client leads the discussion across 24 statements and actively attempts to verbalise feelings and evaluate introjected values. Statement 13 reflects experiencing at level 4, as the client becomes aware of being constrained by long-held ideas about their mother and re-evaluates how these perceptions shape their relational behaviour. Despite this, both raters identified a peak level of 5 (see Table 11.B in Appendix 11), indicating a subtle but meaningful divergence in interpretation rather than inconsistency. In contrast, Transcription #4 consists of a quieter exchange with only six client statements. Although the client reaches experiencing level 3 early using "I" statements, subsequent shifts in focus toward others coincide with fluctuations between levels 1 and 2. Nevertheless, one rater assigned both a peak and mode rating of 4, diverging markedly from the other raters. These examples suggest that EXP ratings may be influenced by how the client's manner of receiving, perceiving, and symbolising experience becomes verbally externalised within interaction. This issue is further compounded when ratings rely solely on written transcripts. Without access to vocal tone, pacing, hesitation, and shifts in emphasis, raters may interpret the same segment differently, particularly in quieter or more inwardly focused exchanges.

Consequently, EXP scores in the present study should be understood as indicators of how a client's manner of experiencing becomes recognisable within a given communicative context, rather than as exhaustive representations of the client's overall experiential engagement in therapy.

Finally, recording procedures themselves may have introduced an additional contextual constraint. For trainee therapists, awareness that sessions were recorded as part of clinic requirements may have limited spontaneous enactment of the three therapists' conditions. Clients may likewise have experienced the recording as inhibiting, reducing willingness to attend inwardly to felt experience. In this sense, the recording functioned as an intrusive third presence within the therapeutic encounter, potentially constraining both relational processes and experiential engagement. While experienced therapists may be less affected, this factor may be particularly salient in training contexts.

Accordingly, EXP ratings in the present study should be interpreted as approximations of clients' experiential engagement within selected segments rather than definitive indicators of sustained experiencing. Differential reliability between peak and mode ratings, combined with timing- and context-related constraints, likely reduced sensitivity to detect the mediating role of experiencing. Null or weak effects involving EXP should therefore not be taken as evidence against its theoretical importance within Rogers' model, but rather as reflecting limitations in the operationalisation and measurement of experiential process under naturalistic and resource-constrained conditions.

9.4.6 Time Constraint

Time constraints limited the extent to which Rogers' six necessary and sufficient conditions could be examined at the level of in-session relational enactment. It was not feasible to incorporate the Person-Centred and Experiencing Psychotherapy Scale (PCEPS) alongside Experiencing Scale (EXP) ratings. Within Rogers' framework, the therapist's conditions are not merely held as internal attitudes but must be enacted in ways that are perceptible and psychologically available to the client. Observational use of the PCEPS would

have enabled direct assessment of therapist relational behaviours, thereby providing an empirical bridge between the therapist's enactment of empathy, congruence, and unconditional positive regard and the client's experiential uptake within sessions.

Murphy and Cramer (2014) emphasised the importance of process-level observation for evaluating how the six necessary and sufficient conditions operate in practice. In the absence of PCEPS, the present study relied on client and therapist self-reports to infer the presence of the therapist's conditions. This approach does not permit direct examination of whether the therapist's conditions were *mutually perceived and received* within the therapeutic encounter, as required for a full operationalisation of Rogers' Condition 6. As a result, although the study can examine the temporal and experiential pathways implied by the six necessary and sufficientconditions, it cannot directly account for the behavioural processes through which these conditions are mutually realised in vivo. This limits the strength of conclusions that can be drawn about the *sufficiency* of the therapist's conditions as enacted relational mechanisms rather than a perceived relational climate.

Additional time and measurement constraints also affected the manner in which the EXP was coded. EXP ratings were conducted by a primary rater who had completed formal training in the use of the scale and then undertook large-volume coding across the dataset. Given the scale's reliance on nuanced judgement of in-session process, optimal practice would involve repeated inter-rater reliability checks throughout the coding period. However, the volume of material and the available timeframe limited the extent to which this could be implemented.

The EXP manual emphasises the importance of inter-rater reliability testing to maintain consistency across raters (Klein et al., 1986). Although

transcriptions can facilitate detailed discussion during inter-rater calibration, the manual also highlights that EXP is best captured through audio recordings rather than written text, and that transcription alone does not enhance the reliability of EXP ratings. As the present study did not aim to analyse thematic content, linguistic detail, or nonverbal behaviour, full transcription of the dataset was not prioritised.

In practical terms, full transcription of approximately 350 audio recordings was not feasible within the available timeframe. An alternative option would have been to transcribe and code a substantially reduced subsample of clients, but this would have limited the longitudinal scope of the study and reduced its capacity to examine developmental patterns across the termination phase. A deliberate methodological decision was therefore made to prioritise breadth of longitudinal coverage over depth of transcription-based reliability procedures.

A limited number of transcriptions were used to support the sharing of rating examples with supervisors and to aid the development and refinement of coding judgments. Although repeated inter-rater reliability checks and extended transcription-based calibration would have further strengthened rater consistency and expertise, it was not possible to conduct another short inter-rater reliability check across the full dataset (70 clients across sessions 1, 5, 10, 15, and 20) within the study's time constraints.

In summary, time and measurement constraints limit the strength of the test of Rogers' six necessary and sufficient conditions, particularly Condition 6. The study cannot demonstrate that the therapist's conditions, as enacted within sessions, were consistently perceived, received, and mutually realised within the therapeutic relationship. In the absence of direct observational data and ongoing reliability checks, Rogers' hypothesis cannot be tested at the level of enacted

relational sufficiency, but only at the level of theory-consistent relational and experiential associations.

9.5 Recommendations for Future Research

This section outlines directions for future research, focusing on client factors, therapist attitudes, and refined longitudinal models to enhance empirical tests of Rogers' six necessary and sufficient conditions.

9.5.1 Therapist Characteristic

Future research on Rogers' hypothesis should explicitly examine therapist characteristics as moderators of relational and experiential pathways, rather than treating therapist variables as background factors. Studies on gender in psychotherapy have primarily used categorical comparisons between male and female therapists and clients, which provide limited insight. Keijsers et al. (1994) found that gender did not reliably predict treatment outcomes, indicating that simple binary gender categories might hide more meaningful relational dynamics. Conversely, Petry and Thomas (1986) reported that therapists with an androgynous sex-role orientation—characterised by a flexible blend of traits traditionally labelled as masculine or feminine—were viewed as establishing more supportive therapeutic relationships on the B-LRI, regardless of gender. This aligns with Rogers' focus on Conditions 3 to 5 as relational attitudes that only become therapeutically effective when perceived by the client (Condition 6). Future research should move beyond binary gender comparisons and explore whether therapist gender-related traits act as contextual moderators influencing client-perceived therapist conditions, client experience, and the progression from alienation to authenticity, employing longitudinal designs that model pathway effects rather than isolated outcomes.

Future tests of Rogers' hypothesis should reconsider how variation in therapy duration and data completeness is conceptualised within longitudinal research designs. Such variation is typically treated as a methodological inconvenience; however, within a relational and process-oriented theory, it may reflect meaningful features of the therapeutic process itself. In the present study, substantial variability was observed in therapy continuation and patterns of missing data. More than two-thirds of clients continued beyond Session 20, with some extending to 40 sessions. Mearns and Thorne (2013) suggest that difficulty ending therapy may reflect the establishment of a strongly facilitative relationship, in which clients wish to continue once a receptive and engaged manner of relating has been achieved. At the same time, therapist-specific patterns of continuation and form completion may reflect variability in the consistent embodiment of empathy, congruence, and unconditional positive regard, particularly within a training-clinic context.

Future longitudinal designs could therefore model therapist effects more explicitly by examining whether therapy duration, continuation versus drop-out, attrition, and patterns of missingness cluster by therapist, and whether such variability is associated with independent assessments of therapists' relational attitudes. Observer-rated measures such as the Person-Centred and Experiential Psychotherapy Scale (PCEPS; Freire, 2013) could be applied to session audio recordings to assess the enacted provision of the therapist's conditions, alongside the Experiencing Scale (EXP; Klein et al., 1986) to capture clients' manner of engaging with experience over time. Parallel therapist- and client-reported versions of the Agnew Relationship Measure (ARM-5; Agnew et al., 1998) could further be administered at regular intervals to examine dyadic correspondence in the early phase of therapy. This integrated approach would allow continuation, disengagement, and drop-out to be examined as potential

process indicators linked to the provision and uptake of the therapist's conditions, rather than being treated solely as methodological limitations.

Further refinement of Rogers' hypothesis also requires closer examination of therapist contributions to differences in clients' levels of experiencing. Variations in experiencing are often interpreted as reflecting client readiness or process capacity, yet they may also be shaped by therapist-related factors that remain underexamined. In the present study, therapist skill, experience, emotional containment, and consistency in the provision of empathy, congruence, and unconditional positive regard were not directly assessed, limiting interpretation of whether clients who remained at lower levels of experiencing did so due to constraints in their own process capacity or variability in therapists' enactment of the conditions. This issue is particularly salient in training-clinic contexts, where therapists may still be developing the capacity to sustain empathic presence and containment, especially with clients who require more time to engage experientially. From a person-centred perspective, differences in experiencing are understood as variations in process capacity rather than resistance or dependency, as articulated in Gendlin's developmental conceptualisation of experiencing, in which lower levels involve referring to feelings rather than from them, and higher levels reflect sustained contact with felt meaning (Gendlin et al., 1960). Future studies could therefore strengthen interpretation of categorical experiencing findings by incorporating independent observer-rated measures of therapist attitudes, such as the PCEPS, alongside EXP, allowing examination of whether lower manners of experiencing are associated with reduced consistency in the enactment of the therapist's conditions rather than limitations in client readiness or motivation.

In summary, these recommendations suggest that variability in therapeutic pathways may reflect differences in the delivery, consistency, and

perception of Rogers' necessary and sufficient conditions rather than limitations of the conditions themselves. Future empirical tests of Rogers' hypothesis would therefore benefit from designs that explicitly model therapist characteristics, relational enactment, and experiential uptake as interacting components within a developmental pathway from alienation toward authenticity.

9.5.2 Advancing the Empirical Evaluation of Rogers' six Necessary and Sufficient Conditions

Future research should refine the analytical model used to test Rogers' six necessary and sufficient conditions for constructive personality change. Such refinement is not intended to revise Rogers' theory, but to bring empirical modelling into closer alignment with its developmental and process-oriented assumptions. A primary recommendation is to use larger samples drawn from the HFP to improve estimation of temporal pathways linking clients' perceptions of the three therapist's conditions to later levels of authenticity. Longitudinal studies examining relational and developmental processes have typically relied on substantially larger samples (e.g., Boyraz et al., 2014), highlighting the importance of sample size for robust inference when testing theoretically ordered pathways.

A further recommendation for future tests of Rogers' hypothesis concerns the temporal alignment between relational experience and its assessment, rather than the modelling framework itself. In the present study, EXP and AS were measured at fixed therapy sessions using synchronised self-report forms. While this approach ensured consistency of data collection, hypothesis-driven research grounded in Rogers' theory may benefit from greater flexibility in the timing of process measurement. Within Rogers' framework, experiential engagement is understood as something that unfolds as clients assimilate the relational climate, rather than as an immediate response to a

single session. Experiencing may therefore exert a delayed influence on later authenticity. Assessing experiencing at a short temporal distance from the sessions, such as one or two days later, may provide a closer approximation of how clients integrate the therapist's conditions before deeper experiential engagement becomes available.

Future studies could also consider offset or staggered assessment schedules in which experiencing and authenticity are measured at different time points. These designs enable researchers to investigate if relational safety comes before experiential engagement without presuming a simultaneous relationship between process and outcome indicators. This recommendation concerns improving the temporal sensitivity of measurement rather than addressing limitations of CLPD per se. By refining when process variables are assessed, future research may be better positioned to examine how therapist-provided conditions are taken up experientially and how this uptake supports movement from alienation toward greater congruence.

A further recommendation for testing Rogers' necessary and sufficient conditions concerns the selection of analytical tools capable of modelling developmental and longitudinal processes. Future research in PCT should move beyond reliance on SPSS and increasingly adopt advanced statistical software that can accommodate latent and within-person dynamics, such as RStudio and, in particular, Mplus. Although RStudio was used in the present study and facilitated the detection of subtle longitudinal associations not visible in SPSS, Mplus would allow a more rigorous examination of the mechanisms implied by Rogers' hypothesis. The HFP database provides a strong foundation for longitudinal testing of the six necessary and sufficient conditions, but its full potential depends on analytical approaches that reflect the process-focused nature of Rogers' theory.

To test Rogers' hypothesis more rigorously, future studies should employ modelling frameworks that conceptualise therapeutic development as a dynamic latent process rather than as associations among observed variables. Mplus supports techniques such as latent growth modelling and multilevel structural equation modelling, which are well suited to small samples and complex longitudinal designs and enable examination of individual trajectories over time. A more suitable approach such as latent growth modelling (LGM) (see also Curran, 2000; Bollen & Curran, 2006) tracks within-person changes, allowing a deeper understanding of how a client's self-alienation decreases, and authenticity increases throughout therapy. LGM would provide a clearer view of clients' personal trajectories in response to changes in the therapeutic relationship, making it a more precise tool for testing Rogers' hypothesis and for examining potential feedback loops between authenticity and other variables (Muthen & Curran, 1997).

Further refinement is also needed in the measurement of the B-LRI when used within longitudinal models. Exploratory factor analysis could be revisited to support the construction of a latent relational variable for use in CLPD or growth models. Alternatively, the mini-B-LRI (Chen et al., 2020) may provide a more parsimonious indicator of clients' perceptions of the three therapist conditions. In addition, future studies should address non-normality in longitudinal data more directly. The Bayesian bootstrap has been recommended as an alternative to traditional bootstrapping methods when distributional assumptions are violated (Ismaila et al., 2007), and may improve estimation when testing Rogers' hypothesis under realistic clinical conditions.

In summary, these recommendations emphasise that future tests of Rogers' necessary and sufficient conditions require refinement in sample size, timing of measurement, and analytical strategy rather than revision of the theory itself. By improving temporal sensitivity, adopting developmental modelling

approaches, and strengthening the representation of relational variables, future research will be better equipped to examine how clients' perceptions of the therapist's conditions are taken up experientially and how this process supports movement from alienation toward greater authenticity over time.

9.5.3 Client Factors and Moderators in Testing Rogers' six Necessary and Sufficient Conditions

Additionally, future evaluations of Rogers' six necessary and sufficient conditions could benefit from a clearer focus on client factors that influence how relational conditions develop over time to motivate growth in a constructive direction. The present model focused on the pathway associating clients' perceptions of the three therapists' conditions (B-LRI), experiencing (EXP), and authenticity, but other mediating or moderating processes may also operate within Rogers' theoretical pathway. As Baron and Kenny (1986) noted, examining additional variables is often necessary to clarify how relationships between predictors and outcomes are realised over time. The manner in which clients engage with their emotions may represent a key step following clients' perception of the therapist's conditions, but further process variables may help explain how experiential engagement becomes consolidated as later authenticity.

Clients presenting different concerns may further moderate how Rogers' six necessary and sufficient conditions are perceived and received within therapy. Future research could therefore examine relational–process–outcome pathways in specific clinical contexts, such as trauma pathways, using measures such as the Horowitz Impact of Event Scale. Zwiercan and Joseph (2018) showed that inward focusing attitudes were associated with lower intrusion and avoidance and higher post-traumatic growth, indicating that inward engagement with experience is particularly salient in trauma processing. In their study, trauma

processing was indexed through self-reported intrusion and avoidance alongside self-reported focusing attitudes. Within the HFP, this same process can be examined using observer-rated EXP derived from therapy audio recordings together with self-reported trauma impact, bringing together observational and self-report perspectives. Combining observer-rated EXP with self-reported trauma measures and client-perceived therapist conditions offers a closer alignment with Rogers' emphasis on both lived experience and its communication within the therapeutic relationship. Integrating these measures would allow future studies to examine whether perceived therapist conditions facilitate inward experiential engagement over time in trauma-exposed clients, and whether the therapist's conditions remain sufficient to support movement toward congruence in contexts characterised by heightened threat, emotional dysregulation, or disrupted self-organisation.

Individual differences in client traits may also shape how experiential engagement translates into therapeutic benefit under the six necessary and sufficient conditions, which are proposed to be sufficient only insofar as they are perceived and taken up by the client. From this perspective, experiential engagement reflects the client-side process through which the therapist's conditions are received and worked with over time. However, experiential depth alone may not fully capture how clients use these conditions within the therapeutic relationship. The present findings suggest that some clients operating at higher EXP levels (e.g., levels 4 and 5) derive less benefit from the therapist's conditions, raising the possibility that elevated experiential intensity may, for certain clients, reflect evaluative or self-critical modes of processing rather than receptive openness.

Future studies should therefore examine whether different manners of experiencing shape how clients engage with the therapist's conditions. For

example, experiential engagement characterised by openness and inward receptivity may function differently from engagement marked by self-monitoring or perfectionistic evaluation (Zuroff et al., 2006). Evidence from the TDCRP supports the importance of this distinction. Elkin et al. (1999) showed that early patient engagement, assessed using the patient factor of the VTAS, was associated with continuation in therapy and more positive perceptions of the therapeutic relationship**.** Blatt and Zuroff (2005) demonstrated that early client perceptions of the three therapist's conditions were associated reductions in perfectionism, and the development of enhanced adaptive capacity, reflecting greater resilience over time. Building on this work, future studies within the HFP could combine EXP ratings with VTAS coding of audio recordings to examine how different experiential stances are enacted within the therapeutic relationship, and how these modes of engagement interact with clients' perceptions of the therapist's conditions across therapy.

Future research could also investigate additional mediating processes that may clarify how Rogers' six necessary and sufficient conditions operate within the therapeutic relationship. One such research tools is relational depth (Wiggins et al., 2012), which captures moments of profound mutual engagement, presence, and psychological contact between client and therapist. In the present study, relational depth was not included because of its conceptual and empirical overlap with the B-LRI, as both measures assess clients' perceptions of the therapist's relational stance. However, relational depth differs in emphasis, focusing on discrete moments of intensified relational meeting rather than the overall relational climate. Future studies could therefore use relational depth to examine whether Rogers' conditions exert their influence through sustained perceptions of the therapist's attitudes, through episodic moments of deep interpersonal connection, or through an interaction of both. This distinction

would allow refinement of the process assumptions within Rogers' hypothesis, moving beyond global perceptions to examine how the therapist's conditions are intermittently enacted, experienced, and consolidated within the therapeutic relationship over time.

Clients' cultural and demographic contexts may moderate how authenticity functions within the therapeutic process and how Rogers' six necessary and sufficient conditions are received and integrated. Although the present study did not include cross-cultural samples, evidence suggests that authenticity does not operate uniformly across cultural backgrounds. Chen and Murphy (2019) demonstrated cultural variation in the relationship between authenticity and well-being, indicating that demographic factors may shape how authenticity is developed, valued, and expressed, even when the therapist's conditions are perceived as present. In their study, mindfulness predicted authenticity and subsequent psychological well-being among Chinese students, whereas this pathway was not observed among White British students. Such findings suggest that cultural socialisation influences how individuals relate to the self, and therefore how authenticity emerges within relational contexts. Future research testing Rogers' six conditions across diverse cultural groups is needed to examine whether the facilitative conditions support authenticity in equivalent ways, or whether their operation is culturally contingent. This has particular relevance for non-directive therapeutic work, where the actualising tendency is assumed to operate universally, yet may be expressed through culturally shaped forms of self-understanding and relational engagement.

Future research should also examine therapy dropout as a theoretically meaningful process, rather than treating it solely as a methodological limitation. Evidence from the TDCRP indicates that early termination is systematically associated with early relational and engagement variables, rather than occurring

at random. Clients who discontinue therapy early tend to report weaker perceptions of the therapeutic relationship and lower early engagement (Beckham, 1992; Elkin et al., 1999). More recent analyses further demonstrate that therapist responsiveness and the early relational atmosphere significantly predict whether clients remain in therapy beyond the initial phase, with higher responsiveness reducing the likelihood of early termination (Elkin et al., 2014). Within the context of the HFP, where therapy is delivered in structured blocks with repeated session-level measurement of client-perceived therapist conditions, the dataset is well suited to extending this work. From a Rogerian perspective, dropout may therefore reflect a failure of the therapist's conditions to be sufficiently perceived and received by the client. Future longitudinal models using the HFP could incorporate dropout as an outcome or competing process, examining whether early client-perceived therapist conditions and experiential engagement differentiate clients who terminate therapy prematurely from those who remain engaged through the termination phase.

Additionally, clients' expressive style represents a contextual factor that may shape how experiential engagement is manifested and recognised within therapy. Stiles et al. (1979) found that higher levels of client experiencing were associated with greater personal disclosure, suggesting that emotional exploration becomes more externally articulated when the therapeutic relationship is perceived as safe and responsive. From the perspective of Rogers' six necessary and sufficient conditions, this raises important questions about how the therapist's conditions are translated into observable experiencing across different communicative styles. Future research could examine how variations in conversational structure influence the coding and interpretation of experiencing, rather than treating such differences solely as measurement limitations. In the present study, segments marked by active verbal exploration sometimes

received different EXP ratings from quieter, inwardly focused exchanges, despite reflecting comparable forms of experiential engagement.

Moreover, in the present findings, experiencing appears to function as a threshold-dependent process; future studies may benefit from examining authenticity using categorical representations rather than relying solely on a global continuous score. As authenticity comprises distinct dimensions—self-alienation, accepting external influences, and authentic living—categorising these subscales may allow a more precise examination of how different levels of peak experiencing relate to specific aspects of authenticity. For example, treating self-alienation categorically may help clarify whether reaching certain experiential levels is associated with reduced alienation, even when overall authenticity does not increase incrementally.

Finally, future research could extend tests of the six necessary and sufficient conditions by examining emotional intelligence (EI) as a mediating process variable. Tohme and Joseph (2020) reported that higher levels of EI were associated with later authenticity, suggesting that EI may represent a meaningful pathway through which earlier perceptions of the three therapists' conditions support later levels of authenticity. Future research could operationalise EI by systematically coding emotionally salient in-session segments, focusing on markers such as emotional recognition, regulation, and reflective meaning-making. Such approaches would allow clearer evaluation of temporal ordering and help determine whether EI functions as a distinct outcome variable, a downstream expression of experiencing, or a complementary pathway alongside EXP.

In summary, these recommendations suggest that future tests of Rogers' six necessary and sufficient conditions would benefit from greater attention to client-related moderators and mediators. Client factors such as early authenticity,

presenting context, individual traits, cultural background, drop out, expressive style, and emotional intelligence may shape how the therapist's conditions are taken up experientially and translated into movement from alienation toward greater congruence. Incorporating these variables does not challenge Rogers' hypothesis, but rather offers a more precise and developmentally sensitive framework for examining how the six necessary and sufficient conditions operate across diverse clients and therapeutic contexts.

9.5.4 Education

Future research would benefit from examining *how* Rogers' six necessary and sufficient conditions operate across different relational contexts, rather than continuing to ask whether they apply beyond psychotherapy. Rogers never confined his relational hypothesis to clinical work. From the 1960s onward, he explicitly extended the facilitative role of empathy, congruence, and unconditional positive regard to educational settings, where learning, autonomy, and self-direction are central aims. The empirical literature reflects this shift. A substantial body of studies using the B-LRI has been conducted in schools and universities, demonstrating sustained and methodologically robust engagement with Rogers' relational assumptions outside therapy.

Educational settings offer a distinctive opportunity to clarify how the facilitative conditions function when therapeutic intent is absent. Unlike psychotherapy, which is organised around psychological distress and formal treatment contracts, educational relationships are role-defined, ongoing, and embedded within everyday interactions. In this context, Condition 1—psychological contact—is not diminished but differently instantiated, arising through sustained teacher–student engagement rather than clinical alliance. This

allows the six conditions to be examined as relational processes rather than as features tied exclusively to therapy.

A dedicated systematic review or meta-analysis of educational studies would therefore represent an important next step. Such work could synthesise how empathy, congruence, and unconditional positive regard are perceived, enacted, and taken up within teacher–student relationships, and how these relational qualities relate to outcomes such as engagement, self-directed motivation, or personal development. Importantly, this approach would shift the focus from outcome confirmation to process clarification, allowing closer examination of how relational conditions organise growth over time in non-clinical helping relationships.

Future research could clarify how the same relational conditions that support constructive personality development in psychotherapy also facilitate growth within structured, non-clinical contexts. In doing so, educational settings may offer not a weaker test of Rogers' hypothesis, but a complementary one—providing insight into the mechanisms through which facilitative relationships support development across diverse relational environments.

Additionally, future research and postgraduate education within the HFP could benefit from the formal integration of structured training in observer-rated process measures. Introducing teaching in tools such as the EXP, VTAS, and PCEPS would increase students' awareness of the different ways Rogers' six necessary and sufficient conditions and stages of process can be operationalised and examined. Because these instruments capture distinct aspects of the therapeutic process, training across multiple tools supports more theoretically informed and comparative assessments of the hypothesis.

Such training should combine theoretical grounding, supervised rating practice, and systematic calibration across raters. Calibration is essential for high-inference process measures and would strengthen the reliability and interpretive coherence of ratings. Within the HFP, where relational and outcome data have already been collected, therapy audio recordings constitute the primary remaining means of extending process-level analysis. Embedding calibrated training within postgraduate education, therefore, provides a practical route to activate existing data, encourage student engagement in research, and contribute additional layers of process information back into the HFP, while strengthening the methodological foundations for future tests of the sufficiency of the six conditions for constructive personality change.

9.6 Conclusion

This thesis neither empirically supported nor refuted the proposed directional claim implied by Rogers' (1957, 1959) hypothesis. Clients' earlier perceptions of the three therapists' conditions were associated with later authenticity; however, the hypothesised unidirectional causal pathway could not be confirmed. These findings do not weaken Rogers' formulation. Rather, they suggest that the combined assertion of necessity and sufficiency exceeds what can be empirically demonstrated once a logically articulated theory is subjected to temporal modelling. A logical claim does not map neatly onto a time-ordered empirical process governed by gradual, non-discrete psychological movement. The resulting tension reflects a methodological limitation rather than a theoretical weakness in Rogers' hypothesis.

From this perspective, authenticity cannot be understood as an immediate outcome of therapy but as a developmental process embedded within an ongoing dialogical relationship. It unfolds gradually as clients become

less discrepant between their lived experience and self-concept, which depends on how the three therapists' conditions are perceived, taken up, and integrated by the client over time. The present findings therefore support an interpretation in which the six conditions are facilitative and probabilistically sufficient, operating within an unfolding relational sequence.

This interpretation raises questions about continued attempts to locate therapeutic outcomes solely within Rogers' six necessary and sufficient conditions. Rogers did not conceptualise constructive personality change as a discrete endpoint or as a mechanism producing fixed outcomes. Instead, the six conditions describe the relational and experiential context within which the client's actualising tendency can operate. Accordingly, the three therapist's conditions are facilitative and probabilistically sufficient only insofar as they are used by the client within an ongoing temporal sequence, rather than functioning as independent causal agents. This implies a shift in research focus away from asking whether the six conditions produce change, toward examining how and when clients use these conditions in the service of their movement toward greater congruence and optimal functioning.

The longitudinal models tested in this thesis were designed to move in this direction. The CLPD, informed by Rogers'(1961) seven stages of process, aimed to capture a progression from early perceptions of the three therapists' conditions to later levels of authenticity. Although clients' experiencing was examined as a potential mediating process, it did not fully account for this progression, suggesting that additional, unmeasured process variables may be involved. This limitation does not indicate theoretical failure but highlights the complexity of operationalising a richly articulated process theory within a corrected longitudinal empirical framework. The proposed model, therefore,

represents a meaningful starting point rather than a definitive test of Rogers' hypothesis.

What is needed is not the abandonment of Rogers' hypothesis, but the development of research designs capable of capturing temporal dependency, relational uptake, and process unfolding over time. Much of the existing literature has examined parts of the hypothesis in a fragmented way, isolating individual conditions or short-term associations rather than testing the hypothesis as a coherent, temporally organised model. As a result, Rogers' hypothesis has neither been definitively rejected nor conclusively confirmed.

Further research is therefore needed to determine whether the hypothesis requires conceptual refinement, whether its propositions are insufficiently specified for empirical testing, or whether the conditions themselves pose challenges for operationalisation within conventional scientific designs. The HFP offers a particularly suitable foundation for such work, providing the longitudinal structure and process-sensitive data required to examine whether, and under what conditions, Rogers' hypothesis can be tested as a unified model of change.

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Appendices

Appendix 1

BASIC 40-ITEM FORMS

Name or code ..... Answer date .....

Barrett-Lennard Relationship Inventory: Form OS–40 (version 3)

Developed by Godfrey T. Barrett-Lennard, PhD

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with _____, mentally inserting his or her name in the space provided. For example, if the other person's name was John, you would read the first statement as "John respects me" and the second as "John usually senses or realizes what I am feeling".

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. *Write in a minus number (–3, –2, or –1) when your answer is on the "no" side, and a plus number (+1, +2, or +3) when your answer is a "yes."* Here is the exact meaning of each answer number:–

+3:	**YES,** *I strongly feel that it is true*	–1:	(No) *I feel that it is probably untrue, or more untrue than true*
+2:	Yes, *I feel it is true*	–2:	No, *I feel it is not true*
+1:	(Yes) *I feel that it is probably true, or more true than untrue*	–3:	**NO,** *I strongly feel that it is not true*

_____ 1. _____ respects me.
_____ 2. _____ usually senses or realizes what I am feeling.
_____ 3. _____'s interest in me depends on my words and actions (or how I perform).
_____ 4. I feel that _____ puts on a role or front with me.
_____ 5. _____ feels a true liking for me.
_____ 6. _____ reacts to my words but does not see the way I feel.
_____ 7. Whether I am feeling happy or unhappy with myself makes no real difference to the way he/she feels about me.
_____ 8. _____ doesn't avoid or go round anything that matters between us.
_____ 9. _____ is indifferent to me.
_____ 10. _____ nearly always sees exactly what I mean.
_____ 11. Depending on my behavior, _____ has a better (or a worse) opinion of *me* sometimes than s/he has at other times.
_____ 12. I feel that _____ is genuine with me.
_____ 13. I know I'm valued and appreciated by _____
_____ 14. _____'s *own attitudes* get in the way of understanding me.
_____ 15. No matter what I tell about myself _____ likes (or dislikes) me just the same.
_____ 16. _____ keeps quiet about his/her real inner impressions and feelings.
_____ 17. _____ finds me rather dull and uninteresting.
_____ 18. _____ realizes what I mean even when I have difficulty in saying it.
_____ 19. _____ wants me to be a certain kind of person.

_____ 20. _____ is willing to say whatever is on his/her mind with me, including feelings about either of us or how we are getting along.

_____ 21. _____ cares for me.

_____ 22. _____ doesn't listen and pick up on what I think and feel.

_____ 23. _____ likes certain things about me, and there are other things he/she does not like in me.

_____ 24. _____ is openly himself (herself) in our relationship.

_____ 25. I feel that _____ disapproves of me.

_____ 26. _____ usually understands the whole of what I mean.

_____ 27. Whether thoughts or feelings I express are 'good' or 'bad' makes no difference to _____'s feeling toward me.

_____ 28. Sometimes _____ is not at all comfortable but we go on, outwardly ignoring it.

_____ 29. _____ is friendly and warm toward me.

_____ 30. _____ does not understand me.

_____ 31. _____ approves of some things about me (or some of my ways), and plainly disapproves of other things (or ways I act and express myself).

_____ 32. I think _____ always knows exactly what s/he feels with me: s/he doesn't cover up inside.

_____ 33. _____ just tolerates or puts up with me.

_____ 34. _____ appreciates exactly how the things I experience feel to me.

_____ 35. Sometimes I am more worthwhile in _____'s eyes than I am at other times.

_____ 36. At moments I feel that _____'s outward response to me is quite different from the way s/he feels underneath.

_____ 37. _____ feels affection for me.

_____ 38. _____'s response to me is so fixed and automatic that I don't get through to him/her.

_____ 39. I don't think that anything I say or do really changes the way _____ feels toward me.

_____ 40. I believe that _____ has feelings s/he does not tell me about that affect our relationship.

Please double check and make sure that you have given an answer to every item. *Thank you for doing so.*

Please note the other person's relation to you, e.g., a personal friend, spouse or partner, mother, or other family member, teacher or supervisor, counselor/therapist .....

.....

Barrett-Lennard Relationship Inventory: Scoring Sheet – 40-item OS, MO, and Obs–40 (adult) forms

Developed by Godfrey T. Barrett-Lennard, PhD

Name/code ..... Date answered .....

Class of relationship ..... Form: OS MO Obs40 (circle one) .....

Position of respondent ..... Note if other RI data on same relationship .....

Enter the answer for each item in its space, below, after reversing the sign (from + to –, or – to +) for the item numbers shown in **bold**. *(The* **bold** *items are worded "negatively.")*

Level of Regard (R)		Empathy (E)		Unconditionality (U)		Congruence (C)	
Item No.	***Answer***	**Item No.**	***Answer***	**Item No.**	***Answer***	**Item No.**	***Answer***
1		2		**3**	Reverse sign	**4**	Reverse sign
5		**6**	Reverse sign	7		8	
9	Reverse sign	10		**11**	Reverse sign	12	
13		**14**	Reverse sign	15		**16**	Reverse sign
17	Reverse sign	18		**19**	Reverse sign	20	
21		**22**	Reverse sign	**23**	Reverse sign	24	
25	Reverse sign	26		27		**28**	Reverse sign
29		**30**	Reverse sign	**31**	Reverse sign	32	
33	Reverse sign	34		**35**	Reverse sign	**36**	Reverse sign
37		**38**	Reverse sign	39		**40**	Reverse sign
R Scale Score->		**E Scale Score->**		**U Scale Score->**		**C Scale Score->**	

Add the 10 values in each answer column to obtain the score for that scale, which might be a positive or negative number. The *possible* range of scale scores is –30 (or –3 × 10) to +30 (+3 × 10). If avoidance of negative values is necessary, add a constant of +30 to each obtained scale score, to yield 'converted scores' with a *possible* range of 0 to 60.

Appendix 2

Reviewer_ _ _ _____
Date_____

Author_____ Year_____ Record Number_____

	Yes	No	Unclear	Not applicable
1. Is the review question clearly and explicitly stated?	☐	☐	☐	☐
2. Were the inclusion criteria appropriate for the review question?	☐	☐	☐	☐
3. Was the search strategy appropriate?	☐	☐	☐	☐
4. Were the sources and resources used to searchfor studies adequate?	☐	☐	☐	☐
5. Were the criteria for appraising studies appropriate?	☐	☐	☐	☐
6. Was critical appraisal conducted by two or more reviewers independently?	☐	☐	☐	☐
7. Were there methods to minimize errors in data extraction?	☐	☐	☐	☐
8. Were the methods used to combine studies appropriate?	☐	☐	☐	☐
9. Was the likelihood of publication bias assessed?	☐	☐	☐	☐
10. Were recommendations for policy and/or practice supported by the reported	☐	☐	☐	☐

data?				
11. Were the specific directives for new research appropriate?	□	□	□	□

Overall appraisal: Include □ Exclude □ Seek further info □

Comments (Including reason for exclusion)

Appendix 3

JBI checklist for Quasi-Experimental Design

	Internal Validity	Choice - Comments/Justification	Yes	No	Unclear	N/A
Bias related to temporal precedence						
1	**Is it clear in the study what is the "cause" and what is the "effect" (i.e. there is no confusion about which variable comes first)?**		☐	☐	☐	☐
Bias related to selection and allocation						
2	**Was there a control group?**		☐	☐	☐	☐
Bias related to confounding factors						
3	**Were participants included in any comparisons similar?**		☐	☐	☐	☐
Bias related to administration of intervention/exposure						
4	**Were the**		☐	☐	☐	☐

	participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?		

Bias related to assessment, detection and measurement of the outcome

5	**Were there multiple measurements of the outcome, both pre and post the intervention/exposure?**		**Yes**	**No**	**Unclear**	**N/A**
	Outcome 1		☐	☐	☐	☐
	Outcome 2		☐	☐	☐	☐
	Outcome 3		☐	☐	☐	☐
	Outcome 4		☐	☐	☐	☐
	Outcome 5		☐	☐	☐	☐
	Outcome 6		☐	☐	☐	☐
	Outcome 7		☐	☐	☐	☐

6	**Were the outcomes of participants included in any comparisons measured in the same way?**		**Yes**	**No**	**Unclear**	**N/A**
	Outcome 1		☐	☐	☐	☐

	Outcome 2		☐	☐	☐	☐
	Outcome 3		☐	☐	☐	☐
	Outcome 4		☐	☐	☐	☐
	Outcome 5		☐	☐	☐	☐
	Outcome 6		☐	☐	☐	☐
	Outcome 7		☐	☐	☐	☐

7	**Were outcomes measured in a reliable way?**		**Yes**	**No**	**Unclear**	**N/A**
	Outcome 1		☐	☐	☐	☐
	Outcome 2		☐	☐	☐	☐
	Outcome 3		☐	☐	☐	☐
	Outcome 4		☐	☐	☐	☐
	Outcome 5		☐	☐	☐	☐
	Outcome 6		☐	☐	☐	☐
	Outcome 7		☐	☐	☐	☐

Bias related to participant retention

8	**Was follow-up complete and if not, were differences between groups in terms of their follow-up adequately described and analyzed?**					
	Outcome 1		**Yes**	**No**	**Unclear**	**N/A**

Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 2		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 3		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 4		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 5		**Yes**	**No**	**Unclear**	**N/A**

Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 6		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 7		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐

Statistical Conclusion Validity

9	**Was appropriate statistical analysis used?**				
	Outcome 1		**es**	**o**	**Unclear**	**N/A**
	Result 1		☐	☐	☐	☐

Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 2		**es**	**o**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 3		**Ye s**	**N o**	**Uncle ar**	**N/ A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 4		**Ye s**	**N o**	**Uncle ar**	**N/ A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 5		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐

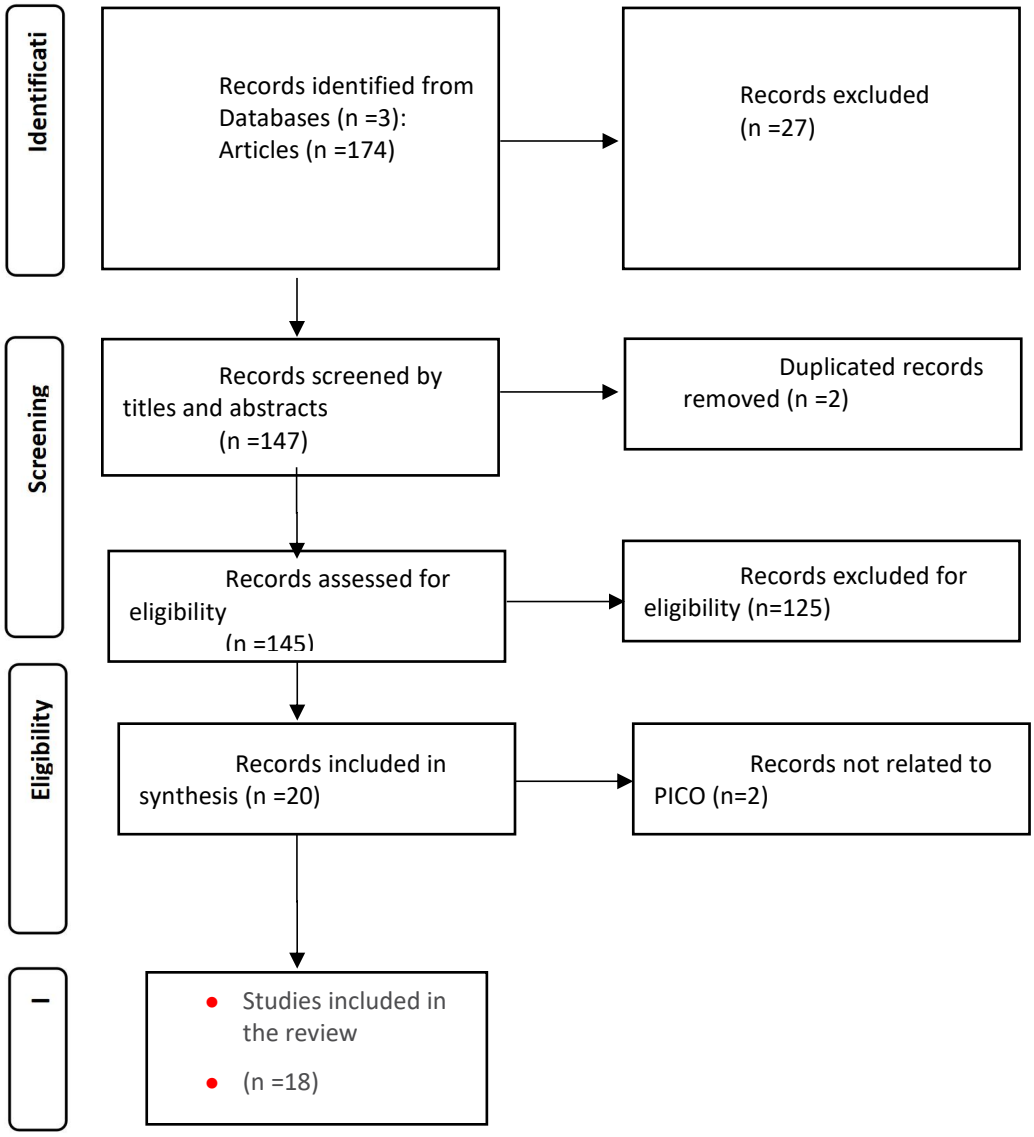
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 6		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 7		**Yes**	**No**	**Unclear**	**N/A**
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐

Overall appraisal : **Include :** ☐ **Exclude :** ☐ **Seek Further Info:** ☐

Comments:

Appendix 4

Figure 4A: Flow Diagram



Notes. Diagram showing the search process according to PRISMA Guidelines 2020 where "n" represents the number of articles

Appendix 5

Table 5A: Item-level Ratings for Risk of Bias assessment

	Authors	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Risk
1	Barnicot et al. (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
2	Barrett-Lennard (1962)	Yes	No	Unclear	Unclear	Yes	Yes	Yes	Unclear	Yes	Moderate
3	Bayliss-Conway et al., (2021)	Yes	No	Unclear	Unclear	Yes	Yes	Yes	Unclear	Yes	Moderate
4	Beckham (1992)	Yes	No	Unclear	Unclear	Yes	Yes	Yes	Unclear	Yes	Moderate
7	Bell, et al., (2016)	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Moderate
6	Blatt and Zuroff (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
5	Blatt et al., (1996)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
10	Dolev and Zilcha-Mano (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
9	Elkin et al., (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
8	Elkin et el., (1999)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
11	Keijsers et al. (1994)	Yes	No	Unclear	Unclear	Yes	Yes	Yes	Unclear	Yes	Moderate
12	Kolb et al. (1985)	Yes	No	Unclear	Unclear	Yes	Yes	Yes	Yes	Yes	Moderate
13	Murphy and Cramer (2014)	Yes	No	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Moderate
14	Payne et al. (2007)	Unclear	No	Unclear	Unclear	Yes	Yes	Yes	Yes	Yes	High
16	Zuroff et al. (2006)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low

15	Zuroff et al. (2000)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
17	Zuroff et al. (2010)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low
18	Zuroff et al. (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Low

Note: Studies were appraised using an observational / quasi-experimental internal validity framework (Barker et al., 2024). Internal and statistical validity questions were rated "*Yes*" when the criterion was clearly met, "*No*" when it was clearly not met, and "*Unclear*" when insufficient methodological detail was reported to permit a justified judgement; Overall risk ratings (Low, Moderate, High) reflect the cumulative pattern of responses across items, with particular weight given to temporal precedence, control of confounding factors, and appropriateness of statistical analysis. For questions (Check Appendices 2 and 3)

Authenticity Scale

Appendix 6

Does not describe me well						Describes me very well
1	2	3	4	5	6	7

1. "I think it is better to be yourself, than to be popular."
2. "I don't know how I really feel inside."
3. "I am strongly influenced by the opinions of others."
4. "I usually do what other people tell me to do."
5. "I always feel I need to do what others expect me to do."
6. "Other people influence me greatly."
7. "I feel as if I don't know myself very well."
8. "I always stand by what I believe in."
9. "I am true to myself in most situations."
10. "I feel out of touch with the 'real me'."
11. "I live in accordance with my values and beliefs."
12. "I feel alienated from myself."

Scoring Instructions

All items are presented on a 1 (*does not describe me at all*) to 7 (*describes me very well*) scale. Total Items 1, 8, 9, and 11 for Authentic Living; Items 3, 4, 5, and 6 for Accepting External Influence; and Items 2, 7, 10, and 12 for Self-Alienation. Wood, A. M., Linley, P. A., Maltby, J., Baliousis, M., & Joseph, S. (2008). The authentic personality: A theoretical and empirical conceptualization and the development of the Authenticity Scale. *Journal of Counseling Psychology*, *55*, 385-399.

Appendix 7

A Scale for the Rating of Experiencing

Eugene T. Gendlin and T.M. Tomlinson
Revised by Philippa L. Mathieu and Majorie, H. Klein
Rogers et al (eds) (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics*. Madison: University of Wisconsin Press.

Summary Rating Sheet

Process Rating scale for Psychotherapeutic Interviews: Experiencing Dimension. The extent to which the client manifests inward reference in his verbalizations. The client is referring inwardly when he is referring to his own feelings and reactions – when he is searching for the meaning of the personal events, feelings, and ideas he is reporting.

Features	Stages	Scoring
Freedom to move among feelings and their significance from an experiential frame of reference.	7. The client does not need a narrative as a point of departure. He can travel freely among feelings and understands them quickly. The client has no difficulty in tying together what he is saying and presenting a clear picture of himself – what meaning his thoughts, actions and feelings have foe him. He moves easily from one inward reference to another and is able to integrate them into his experiential frame of reference.	
Able to arrive at a conclusion based on insight into the significance of his feelings.	6. Feelings become content. If there are situational associations they are understood in terms of the personal significance of the feelings associated with them.	
Defines a problem in terms of feelings and attempts to explore this.	5. Exploration of (a) one situation or aspect of self-image involving many feelings and their potential relationship, or one feeling area (if well described) and its	

	personal significance; (b) many situations examined in terms of the common feelings or significance involved.	
Person communicates what it is like to *be* him.	4. Several ways it can be *4*: Either fluid expression of many feelings, or expression of one feeling and time spent elaborating on it in terms of the significance of self-image; or a specific expression of the fact that the feelings exist, but that help is required to express them.	
Affective involvement *does* go beyond specific content but *passes by* deeper meanings.	3. Expressions of personal and "owned" feelings used as parenthetical comments to the narrative. Personal feelings are still (a) tied completely to situations in which they arise, or (b) unelaborated in terms of deeper personal meaning or significance.	
Ownership of personal role in narrative.	2. Personal reference used to clarify that it is clearly *his* story.	
No personal involvements.	1. No personal reference used. Narrative of events describing what amounts to a public picture. Denial or refusal of personal involvement.	
Rater._____ Segment No_____		Code √ = Peak rating X = Modal rating

Appendix 8

Demographic Questions

HFP entry Date: _____ HFP exit Date: _____

Age _____ 2. Gender:

Male Female

Ethnicity_____

Therapist Gender_____

Therapist Number of Clients_____

Clients' Unique Code: _____

Appendix 9

Coding example for Regression

```
# # # # Step1: Linear Regression Between B-LRI at session 5 on AS at session 10
S5lriS10a = lm(SumAuthenticityS10 ~ SumBLRIS5, data = dataset)

summary(S5lriS10a)

confint(S5lriS10a)

# Standardize the model

Model1 <- lm(scale(SumAuthenticityS5) ~ scale(SumBLRIS5), data = dataset)

summary(standardized_model)

confint(standardized_model)

 # # # # Step2: Multiple Regression for AS at session 10 against B-LRI at session
5, authenticity at session 5 and B-LRI at session 10
 S5lriS10a = lm(SumAuthenticityS10 ~ SumBLRIS5 + SumAuthenticityS5 + SumBLRIS10, data =
dataset)

summary(S5lriS10a)

confint(S5lriS10a)

# Standardize the variables

model2 <- lm(scale(SumAuthenticityS10) ~ scale(SumBLRIS5) +
scale(SumAuthenticityS5) + scale(SumBLRIS10), data = dataset)

summary(standardized_model2)

confint(standardized_model2)

# # # # Step 3 : Compute R-squared change value

rsq_model1 <- summary(model1)$r.squared

rsq_model2 <- summary(model2)$r.squared

 # # # # R-squared change

rsq_change <- rsq_model2 - rsq_model1
```

```
rsq_change

anova(model1, model2)
```

Coding example for SEM

```
Model <- '

 # latent variables

BLRI5 =~ SumBLRIS5

 BLRI15 =~ SumBLRIS15

 AS5 =~ SumAuthenticityS5

 AS15 =~ SumAuthenticityS15

  # regressions

AS15 ~   BLRI5 + AS5   # Paths from BLRI S5 and ATH S5 to ATH S10

BLRI15 ~  BLRI5 + AS5  # Paths from BLRI S5 and AS S5 to BLRI S10

# residual covariances

AS5 ~~ BLRI5

BLRI15 ~~ AS15

'

# Fit the structural equation model with bootstrapping

fit3 <- sem(model = myModel, data = dataset, missing = "ML", se = "bootstrap",
bootstrap = 1000)

 summary(fit3)

 # Extract parameter estimates

estimates <- parameterEstimates(fit3)

b1 <- estimates$est[estimates$lhs == "AS15" & estimates$rhs == "BLRI5"]

b2 <- estimates$est[estimates$lhs == "BLRI15" & estimates$rhs == "AS5"]

 # Calculate the difference b2 - b1

b_diff <- b2 - b1

 # Print the difference

b_diff
```

```
# Extract standard errors for the paths

se_b1 <- estimates$se[estimates$lhs == "AS15" & estimates$rhs == "BLRI5"]

se_b2 <- estimates$se[estimates$lhs == "BLRI15" & estimates$rhs == "AS5"]

 # Calculate the standard error of the difference

se_diff <- sqrt(se_b1^2 + se_b2^2)

 # Calculate the z-value

z_value <- b_diff / se_diff

z_value
```

Coding example for Mediation

```
# 40 Perform mediation analysis for SumAuthenticityS15 against SumBLRIS5 through PeakS10

model1 = lm(SumAuthenticityS15 ~ SumBLRIS5 + PeakS10, data = dataset)

mediation_mode = lm(SumAuthenticityS15 ~ PeakS10, data = dataset)

mediation_analysis = mediate(mediation_mode, model1, treat = "SumBLRIS5", mediator = "PeakS10", boot = TRUE, sims = 1000)

summary(mediation_analysis)
```

Appendix 10

Table 10.A: The B-LRI Items together with their Loadings on the Three-factor Solution

Item factor loadings	*F1*	*F2*	*F3*
31. My therapist approves of some things about me (or some of my ways), and plainly disapproves of other things (or ways I act and express myself)	0.8		
35. Sometimes I am more worthwhile in my therapist's eyes that I am at other times	0.7		
17. My therapist finds me rather dull and uninteresting	0.7		
25. I feel that my therapist disapproved of me	0.7		
33. My therapist just tolerates me or puts up with me	0.7		
40. I believe that my therapist has feelings s/he does not tell me about that affect our relationship	0.6		
23. My therapist likes certain things about me, and there are other things he/she does not like in me	0.6		
11. Depending on my behaviour, me therapist has a better (or a worse) opinion of me sometimes that s/he has at other's times	0.6		
6. My therapists reacts to my words but does not see the way I feel	0.6		
28. Sometimes my therapist is not all comfortable, but we go on, outwardly ignoring it	0.6		
3. My therapist's interests in me depend on my words and actions (or how I perform)	0.6		
36. At moments I feel that my therapist's outward responses to me is quite different from the way s/he feels underneath	0.5		
4. I feel that my therapist puts on a role or front with me	0.5		
19. My therapist wants me to be a certain kind of person	0.5		
9. My therapist is indifferent to me	0.5		
21. My therapist cares for me		0.74	
20. My therapist is willing to say whatever is on his or her mind with me, including feeling either of us or how we are getting along		0.66	
5. My therapists feel true liking for me		0.65	
12. I feel that my therapist is genuine with me		0.61	
24. My therapist is openly herself or himself in our relationship		0.63	

32. I think my therapist always knows exactly what she or he feels with me; she or he doesn't cover up.	0.62	
37.My therapist feels affection for me	0.57	
34. My therapist appreciates exactly how the things I experience feel to me.	0.54	
13. I know I am valued and appreciated by my therapist	0.54	
26. My therapist usually understands the whole of what I mean		0.6
27. Whether thoughts or feelings I express are or good or bad makes no difference to my therapist's feelings toward me		0.6
7. Whether I am feeling happy or unhappy with myself makes no real difference to the way he/she feels about me		0.6
10. My therapist nearly always sees exactly what I mean		0.5
8. My therapist doesn't avoid or go round anything that matters between us		0.5
18. My therapists realises what I mean even I have difficulty in saying it		0.5

Note. This table shows only the B-LRI items that are retained in the three-factor solution. The items are organised based on data-driven factors, which do not match the original B-LRI scale structure.

Table 10.B: The B-LRI Items that did not load on the Three-factor Solution

Item	Subscale
1. My therapist Respect me	LOR
2. My therapist usually senses or realises what I am feeling	E
14. My therapist's own attitudes get in the way of understanding me	E
15. No matter what I tell about myself my therapist likes or dislikes me just the same	U
16. My therapists keeps quiet about his/her real inner impressions and feelings	C
22.My therapist doesn't listen and pick up on what I think and feel	E
29. My therapist is friendly and warm towards me	LOR
30. My therapist doesn't understand me	E
38. My therapist's response to me is so fixed and automatic that I don't through to him/her	E
39. I don't think that anything I say or do really changes my therapist feel towards me	U

Note: This table lists 10 B-LRI items that did not load in the three-factor solution; E: Empathy Items; C: Congruence Items; U: Unconditionality Items; LOR: Level of Regard Items

Appendix 11

Table 11.A: Transcription Code for clients EXP across time

Client Number	Time	Transcription
Client 12	Session 5	Transcription 1
Client 12	Session 20	Transcription 2
Client 26-3	Session 1	Transcription 14
Client 28	Session 1	Transcription 3
Client 28	Session 5	Transcription 11
Client 28	Session 10	Transcription 9
Client 28	Session 15	Transcription 7
Client 28	Session 20	Transcription 5
Client 50	Session 1	Transcription 4
Client 50	Session 5	Transcription 8
Client 50	Session 10	Transcription 16
Client 50	Session 15	Transcription 6
Client 50	Session 20	Transcription 10
Client 117	Session 5	Transcription 17
Client 117	Session 10	Transcription 13
Client 117	Session 15	Transcription 12
Client 117	Session 20	Transcription 15

Note. Five clients were selected for transcription. Seventeen transcripts were used to compile a randomised booklet for rater assessment and calibration across the early, middle, and termination phases of therapy.

Table 11.B: Modes and Peaks for Individual Ratings

(T) Code	Mode (Rater 1)	Peak (Rater 1)	Mode (Rater 2)	Peak (Rater 2)	Mode (Rater 3)	Peak (Rater 3)
1	3	4	3	5	4	5
2	1	2	2	3	3	5
3	2	3	3	4	2	3
4	1	3	3	3	2	3
5	2	3	2	3	2	3
6	1	2	2	3	1	2
7	2	3	2	3	2	4
8	1	2	2	2	1	2
9	3	3	3	4	4	5
10	4	4	4	4	3	5
11	2	3	2	3	2	3
12	2	4	3	4	4	5
13	3	4	4	5	4	5
14	2	3	4	4	2	3
15	2	3	3	4	3	4
16	2	2	3	4	3	3
17	3	3	3	4	4	4

Note. T= Transcription; Mode and Peak rating for the Experiencing scale among raters.

Appendix 12

Transcription Examples

Transcription # 1

C1: I really find it hard. I really don't know why…

T: Being too close to her…

C2: Everything else is fine. It's just in my room. Because the moment I went into her room, I calmed down.

T: It sounds like something quite primary,

C3: It is…

T: ...like something quite deep. And it's hard to identify this thing, but it sounds like it's something very deep. It's not understood, but it's being experienced.

C4: Yeah. Right that something else to put in place.

T: That is something I believe to explore it. You could focus on this feeling whenever it happens again,

C5: I will try to…

T: …try to explore it. I believe some answers are there.

C6: Yeah. I just need to discover it, but it is something new about myself that I didn't quite realize about.

T: Some of these things are still there.

C7: …a little bit, I suppose.

T: Yeah, of course. Of course.

C8: Yeah. That's something else to explore because that's a building block. We'll be doing her one on one later with her friend. So, I'm going to go towards <Stones> and practice before we meet. Mom's going to deliver up onto…and I pushed it to do it, herself. So, I need to do print her a copy.

(Clients yawns)

T: Okay. So that is in the process. The process is going. Your mom is learning. You're working hard,

C9: Very hard, very hard but it's all positive. Mom will learn a lot more about herself through this process than she's ever been able to.

T: Something that you say is very good for her. Very challenging. Very good. Very positive.

C10: Yeah, very good very positive. I do need to work on my relationship with my mother if you need to send her love. It's probably an old behaviour for me, being in my space, maybe representing. Representing failure. (About to cry)

T: Failure?

C11: Failure in the way that you know she chose dad; she didn't walk away from him. Maybe in the way that she chose to be in relationship with Dave……I think…

T: She chose them while she had something very valuable and important that she could have chosen instead.

C12: She could have chosen us.

T: And maybe that's what it is.

C13: Maybe a part of me still blames her. I mean, it may be unfair to say not to go with Dad because I wouldn't have been born, but maybe to wait to leave him. And that's the selfish part of me. Because I do get it, and I do understand. I think sometimes maybe I still look at mom as the old mom rather than the new that is trying…. Sometimes I immediately… I want to hold her accountable for that.

T: That experience is still there. It seems to be there.

C14: Yeah. I've not thought about it for a long time.

T: Why can't you look after me? You said selfish, but us, **C15:** That's essentially it. Why couldn't you have picked us? **T:** Why couldn't have you look after us? Why couldn't have you look after me and be all and give me what I need?

C16: Yeah.

T: Damn it, give me what I need.**C17:** Yeah. Basically, like you've chosen us now, but you chose me when I was 23, not when I needed you.

T: Right. When you're already done.

C18: The hard part is over now.

T: Right, when you're already brought up working independent,

C19: She chose Catherine because Catherine is more needy. I think maybe that's it. that's good that we can work through that and that's good that we can put those steps in, and I feel like I waws doing that, but maybe I'm not that's the first thing that pops into my head when I'm being very relaxed and very open.

T: That's the first thing that's the first natural thing that pops in.

C20: While thinking about it. Yeah

T: Yeah. It sounds like a very honest, very primary emotional everybody needs mom. We mention your inner child that is still somewhere there.

C21: Somewhere happier a lot more content a lot better

T: This child is not in a bad condition. It seems that this child still has some emotions that are not quite easy.

Transcription # 4

C1: When I was… the last job I did, I was a pad coater. And that, you see as mainly as like a floater as well, but people are all forced to do their job. And I was on the soil and one of the bosses, I had to set the angle for it, for the cork. So, every so often, it's like you have to make them… put them over to the gig to fit them in to make sure that it's the right size. And after a while, I did this one and it went right. And I haven't done that badly but anyway, I told the boss. And I'm like, I knew he'll be mad, and I said Well "You set the angle" and he said, "Well you must have knocked it" and I said, "Well, you couldn't have set it right because otherwise, it would have been tight and I wouldn't have been able to knock it." Now he stormed off and, like I let go and write proper I would go. Because he knows I would have said something back. And that was the time when I was drinking heavily. A drink before I go to work and a drink at work. I'd have miniatures in my coat so every time I wanted to go to the toilet, I'd have a drink. And if anybody said, if they suspected, I'd say "Oh that was from last night." That was when I was in a really bad relationship and that did a lot of damage. Took a lot out of me and…

T: And the drinking provided you with a sense of comfort from that loss of dignity.

C2: Uh.. It was. I didn't… I don't know whether I was in denial about that, because was I always making excuses up for her of why she did something, she did suffer from that, can't recall it, PMS? And… but like, she was like it all the time, so I don't know. And um… yeah, I used to drink just to-just to knock myself out. And she was older than me. She was 15 years older than me, and she had a daughter. She had left school the year before, I think, and her son was about seven years younger than me-something like that. And I'd go downstairs and like, they'd always be arguing, her son and her. I just wanted to get away from it, so I used to go upstairs, and I got my own telly up there, and then the one downstairs broke. So, it's like, it came into the bedroom, and they were all watching it in the bedroom. And I just checked that and went downstairs. I was bothered about it. But her daughter could do nothing wrong.

T: Sounds like space was very important to you in that situation. Sounded like a… sounds like a very difficult situation, a very uncomfortable situation to be in with that volatility.

C3: Yeah. Unfortunately, though, the way she was, made me like really jealous, and with the alcohol it made me spiral out of control. But she was messing about it. I know she was. At the end of the mess, it meant something.

T: I'm quite happy to carry on with this conversation if you'd like next week, at the same time.

C4: Yeah.

T: If you so wish.

C5: Yeah, yeah, because there is some stuff from that time, so…

T: Very much, yeah. I look forward to seeing you next week.

C6: Yeah, if I'm awake (client laughs).

T: If for any reason you can't make it, as much notice as possible is great. Just with an e-mail or whatever. Did you say you prefer e-mail? Or did you prefer phoning?