

1 Manuscript title: Clients' Experiences of Shared Decision-making in an Integrative  
2 Psychotherapy for Depression

3 Running title: Clients Experiences of SDM in Psychotherapy

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## Summary

14           Mental health and general healthcare research has shown that practitioners  
15 can facilitate patient involvement in shared decision-making (SDM) and that the  
16 approach can benefit patients who wish to take part in decisions around their care.  
17 Yet, patient experiences of shared decision-making within a psychotherapy context  
18 have been little researched. This study examined how clients experienced shared  
19 decision-making in a collaborative–integrative psychotherapy.

20           A grounded theory approach used interpersonal process recall interviewing  
21 and supplementary semi-structured interviews to investigate 14 clients’ experiences  
22 of SDM in pluralistic psychotherapy for depression.

23           Verbatim transcripts were coded into 819 meaning units across six categories  
24 containing 13 sub-components that comprised a single, core category. The six  
25 categories were: (a) Experiencing decisions as shared, (b) Psychotherapists  
26 supporting clients to become more active in the decision-making process, (c) Both  
27 parties presenting and recognising expert knowledge, (d) Clients felt recognised as  
28 an individual and accommodated for by their psychotherapist, (e) Clients felt  
29 comfortable engaging with the decision-making process, and (f) Daunting for clients  
30 to be asked to take part in decision discussions. A core category emerged of:

31           “Psychotherapists encourage client participation and progressively support clients to  
32 provide information and contributions towards shared treatment decisions that could  
33 be led equally, or marginally more by one party”. Such support was particularly  
34 useful when clients had difficulty contributing as part of decision discussions.

35           Client preferences for shared decision-making change across clients and  
36 across decisions, highlighting the importance of practitioners remaining flexible to  
37 individual clients when using the approach.

38           **Keywords:** shared decision-making; client experience; interpersonal  
39 process recall; communication; psychotherapy; counselling.

40           There is limited research examining shared decision-making (SDM)<sup>1 2 3</sup> in a  
41 psychotherapy context. However, mental health and psychotherapy findings show  
42 that some clients do want to take part in their treatment decision-making. Adams<sup>4</sup>,  
43 for instance, found that adult clients from community care settings who lived with  
44 severe mental illness wanted more involvement in their psychiatric care decisions  
45 than they had previously experienced. Similarly, Kenny<sup>5</sup> presented an interpretative  
46 phenomenological analysis of interviews with five psychotherapy clients, with  
47 reports that they expected to hold a central, collaborative role throughout treatment  
48 alongside their psychotherapist.

49           Experiences of SDM in psychotherapy may differ from experiences in other  
50 healthcare contexts. Psychotherapy decisions can be relatively complex, addressing  
51 such issues as how the psychotherapy dyad works together or how a conversation  
52 may happen, the methods used and content of individual sessions, and more  
53 structural decisions such as times of appointments.<sup>6</sup> Such decisions are usually  
54 framed around the client's difficulties, identified through joint exploration or  
55 psychotherapist interpretation.<sup>7</sup> Psychotherapists and clients then work together to  
56 resolve these difficulties in subsequent psychotherapeutic interactions.<sup>8</sup> By contrast,  
57 the majority of healthcare decision-making may involve less abstract decisions  
58 whereby patients report symptoms to a practitioner in seeking a solution for a  
59 difficulty.<sup>9</sup> A treatment or treatment options can then be put in place by that  
60 practitioner, or the patient referred to a specialty practitioner. An exception within  
61 healthcare is the continual shared decision-making relationship suggested in  
62 managing long-term conditions.<sup>10</sup>

63           Meta-analytical data suggests that accommodating clients' preferences in  
64 psychotherapy decisions can be beneficial. Swift et al. reviewed 53 studies that  
65 examined the impact of accommodating for client preferences on treatment outcomes  
66 and dropout.<sup>11</sup> There was a small, significant effect size on treatment outcomes in  
67 favour of preference accommodation in psychotherapy. They also showed across 28

68 studies that clients who were not matched to their preferred treatment conditions  
69 were 1.79 times more likely to dropout than those that were matched.

70         However, there remains a lack of research exploring client experiences of  
71 shared decision-making in psychotherapy. Findings from one study are available  
72 from a grounded theory analysis of family psychotherapy in a Norwegian outpatient  
73 setting.<sup>12</sup> Families reported one helpful aspect of their treatment was having choice  
74 around the organisation of the therapeutic work. These choices included how, where,  
75 when, and with what psychotherapist to work with. Families also felt collaboration  
76 was part of a helpful relationship with their psychotherapist. This consisted of  
77 families feeling their psychotherapist had listened to them, heard them, took them  
78 seriously, and gave them opportunities to pursue preferred goals and methods. This  
79 suggests that these clients had both a desire to be involved in their treatment  
80 decisions and found doing so to be helpful.

81         Research in mental health and general healthcare can help inform an  
82 understanding of how clients might experience SDM in psychotherapy. For example,  
83 Duncan et al. reviewed studies examining SDM interventions in mental health  
84 contexts.<sup>13</sup> They reported one study that showed a SDM intervention to have a  
85 positive impact on patient treatment satisfaction, and another that did not. They also  
86 concluded that no studies measured patient satisfaction with decisions, nor patient  
87 experiences of their interactions with their practitioner during SDM. Later, Brom et  
88 al. reported that patients in a cancer outpatient context felt they were involved in  
89 their treatment decision-making and were satisfied with it.<sup>14</sup> Additionally,  
90 Thompson and McCabe reviewed practitioner-patient communication across 23  
91 studies in mental health contexts to determine any impact on treatment adherence.<sup>15</sup>  
92 Their narrative synthesis showed shared decision-making and collaborative  
93 communication is associated with greater treatment adherence. Further, a lack of  
94 patient-perceived shared decision-making has been associated with antidepressant  
95 non-adherence and early non-persistence.<sup>16</sup>

96 Healthcare evidence also shows that practitioners can facilitate patient  
97 involvement in shared decision-making through the types of responses they give and  
98 the questions they ask. For example, Henselmans et al. examined cancer patient  
99 experiences of shared decision-making with oncologists in a palliative care setting.<sup>17</sup>  
100 This showed that patients provided additional “preference talk” when oncologists  
101 replied with empathy, checking questions, or reflected a patient’s preferences. In  
102 other instances, patients did not offer further preference talk when their oncologist  
103 provided neutral responses or personal agreements.

104 Most recently, Samalin et al. reviewed the effects of shared decision-making  
105 interventions and decision aids on patients living with mood disorders.<sup>18</sup> They  
106 presented evidence from randomised control trials in two primary care settings<sup>19 20</sup>  
107 one outpatient setting,<sup>21</sup> and one pharmacy routine practice setting<sup>22</sup>. Samalin et al.  
108 reported that intervention groups, compared to controls groups, had greater patient  
109 participation and satisfaction,<sup>19 20</sup> greater medication adherence and treatment  
110 satisfaction,<sup>22</sup> greater patient and physician comfort with the decision made,<sup>19</sup>  
111 greater overall functioning, and reduced depression symptoms at six months and 12  
112 months.<sup>21</sup>

113 Research examining shared decision-making across helping professions has  
114 offered findings showing the approach could have a positive impact on client  
115 experiences of psychotherapy and treatment outcomes. Therefore, it would be useful  
116 to develop a direct understanding of client experiences of the approach within a  
117 psychotherapy context. To develop this, this study aimed to build a comprehensive  
118 account of client-reported experiences, guided by three research questions:

- 119 1. How did clients experience the shared decision-making process in  
120 psychotherapy?
- 121 2. What was the impact of the shared decision-making process on the  
122 client?

123 3. What elements of the interaction during the decision-making process  
124 did clients find helpful for facilitating shared decision-making?

## 125 **Method**

### 126 **Design**

127 This investigation used a qualitative design. Data were collected using cued-  
128 recall and semi-structured interview methods within a Grounded Theory approach<sup>23</sup>  
129<sup>24</sup> and analysed via a grounded theory method adapted for psychotherapy research.<sup>19</sup>  
130 The use of the two interview methods within a grounded theory approach served first  
131 to improve the accuracy in which participants recalled decision-making events, and  
132 second, to follow up on those decisions and any emerging decisions occurring later  
133 in treatment.

### 134 **Participants**

135 Participants were the first 14 adult clients referred to a university research  
136 clinic. All clients took part in an assessment before interview. Clients were seeking  
137 treatment for depression and had a Patient Health Questionnaire-9 score at  
138 assessment greater than or equal to 10.<sup>25</sup> The 14 clients were undergraduate or post-  
139 graduate students; and had a mean age of 21.6 years old and ranged from 18 to 34  
140 years. A majority of clients were female (71.4%,  $n=10$ ). In terms of ethnicity, clients  
141 were predominantly white, British (78.6%,  $n=11$ ), followed by other, Mixed (7.1%,  
142  $n=1$ ), and unknown (14.3%,  $n=2$ ). Three clients reported living with a disability  
143 (21.4%). A minority of clients were taking anti-depressant medication at the time of  
144 assessment (35.7%,  $n=5$ ). Clients completed an average of 14.5 weekly sessions, out  
145 of a maximum of 24. Clients were not required to attend a minimum number of  
146 sessions. Over half of clients had planned treatment endings (57.1%,  $n=8$ ). The other  
147 six clients ended treatment due to self-discontinuation of treatment, non-attendance,  
148 or situational factors such as address re-location.

### 149 **Procedure and Materials**

150 **Pluralistic psychotherapy for depression.**

151 Pluralistic psychotherapy for depression (PfD) is a manualized,  
152 collaborative–integrative psychotherapy,<sup>26,27</sup> with evidence of acceptable treatment  
153 outcomes.<sup>28</sup> It consists of one 90-min assessment session followed by up to 24  
154 sessions of one-to-one psychotherapy. In PfD, the psychotherapist draws on a range  
155 of established methods (e.g., active listening, Socratic dialogue) with the aim of  
156 tailoring the intervention to the specific goals and preferences of the client (Cooper  
157 & McLeod, 2011). As such, PfD strongly encourages the use of SDM, or  
158 “metatherapeutic communication”,<sup>29</sup> throughout the psychotherapy (including at  
159 assessment), to help establish goals, tasks, and methods for the therapeutic work.  
160 This is supported through the use of two “decision tools”: the Goals Form,<sup>30</sup> a brief  
161 goal-setting and monitoring measure; and the Cooper–Norcross Inventory of  
162 Preferences (C-NIP),<sup>31</sup> an 18-item measure which invites the client to indicate their  
163 psychotherapy preferences on a range of dimensions (e.g., “Focus on my past” vs.  
164 “Focus on my future”).

165 PfD assessment sessions provided an opportunity for psychotherapists and  
166 clients to meet; and for psychotherapists to provide clients with an overview of the  
167 treatment. Psychotherapists and clients then had an opportunity to explore the  
168 clients’ concerns and historical background; and to discuss goals, tasks, methods,  
169 and other contractual issues for the psychotherapy.<sup>32</sup>

170 The PfD intervention was delivered by eight psychologists: five females and  
171 two males; three fully qualified practitioners and four doctoral level trainees on  
172 counselling psychology programmes (data on the eighth psychotherapist were not  
173 available). The psychotherapists had been trained in a range of methods, including  
174 humanistic, psychodynamic, and CBT; and all subscribed to a pluralistic model of  
175 practice. Psychotherapists were asked to study, and practice in line with, the  
176 pluralistic psychotherapy for depression manual. However, no specific skills training  
177 on this model was given and adherence to PfD was not formally assessed.

178           **Interpersonal process recall.**

179           This investigation used a cued-recall interview method (Interpersonal Process  
180 Recall; IPR) to help clients remember and report their experiences.<sup>33 34 35</sup> This  
181 method uses audio or video recordings of an interviewee's previous interactions as  
182 cues to help them generate rich observations of their experiences. The IPR method  
183 has previously shown validity and reliability. Elliott et al used ratings of helpfulness  
184 and empathy during IPR interviews to show internal reliability across ratings ( $\alpha=.5$   
185 to .66).<sup>36</sup> Others have indicated adequate convergent validity through positive  
186 correlations between psychotherapist and client ratings of helpfulness.<sup>37 38</sup>  
187 However, Elliott suggests the IPR method is associated with much variability in  
188 responses.<sup>34</sup>

189           Clients took part in IPR interviews following their psychotherapy assessment  
190 and immediately prior to their first treatment session. This provided immediate  
191 support for the client, should they have experienced any distress from revisiting  
192 recordings of their assessment session. IPR interviews lasted 70 to 90 minutes,  
193 although one interview was shorter and lasted 50 minutes. Interviews began with an  
194 explanation of IPR, the purpose of the interview, and what would be expected of  
195 clients in taking part. Next, clients had the opportunity to practice the IPR method  
196 with an example audio unit. A client would then play and pause audio units on a  
197 handheld device, offering commentary on the recording. Providing this control over  
198 the device follows IPR recommendations towards helping participants to feel safe  
199 and encouraging open, honest responses.<sup>27</sup> Questions and prompts were used  
200 throughout the interviews in response to a client, or if the client did not initiate an  
201 observation.

202           **Decision-making audio units.**

203           To select units of audio for interview playback in the IPR interviews, the first  
204 author reviewed audio recordings of the clients' assessment sessions. IPR suggests  
205 that this approach to audio unit selection is appropriate for examining specific events



206 <sup>38</sup> and should be interpersonally weighted, that is, containing exchanges of talk  
207 between both psychotherapist and client, rather than talk from a single speaker only.  
208 <sup>39</sup> Units were selected if they contained talk relevant to psychotherapy decisions: for  
209 instance, talk about psychotherapy goals, preferences, methods, therapeutic  
210 contracts, or session practicalities. <sup>27</sup> Audio units were not constrained by length of  
211 speech or numbers of speaking turns, but by topic shift: for example, if the  
212 discussion moved from discussing a psychotherapy goal to discussing a possible  
213 time for appointments.

#### 214 **IPR question and prompt sheet.**

215 The interviewer asked clients questions and prompts following the clients’  
216 playback of audio units. Questioning focused on past experiences, rather than the  
217 clients’ present thoughts and feelings, to help clients respond to audio units and  
218 questions as an observer. <sup>40</sup> This observer focus was further maintained through  
219 using sentence stems such as “As you reflect on that moment in psychotherapy...”  
220 and “taking a step back from that moment...”.

221 Prompts and questions were informed by existing psychotherapy and IPR  
222 literature. <sup>24 27 34 40 41</sup> Example questions include: “What was your role in the  
223 interaction?” and “What were your impressions of the psychotherapist’s actions at  
224 that point?”

#### 225 **Supplementary interview schedule.**

226 Eleven clients took part in supplementary, semi-structured interviews  
227 immediately before their fifth treatment session. These interviews lasted between 30  
228 and 58 minutes. Three clients were unable to attend these interviews due to  
229 unplanned treatment endings ( $n=2$ ) or limited client availability ( $n=1$ ).

230 The purpose behind these supplementary interviews was to clients to re-  
231 examine assessment decisions and any emerging decisions from the first four  
232 treatment sessions. These interviews served to supplement the cued-recall interviews  
233 by gaining client perspectives on their decisions now and the evolution of those,

234 rather than observations of the how decisions occurred during assessment. Decisions  
235 discussed during interview included those made at assessment and review using the  
236 Goals Form and the Cooper-Norcross Inventory of Preferences. Therapists explained  
237 to clients during sessions that these forms were tools that could aid decision-making  
238 in how the dyad were to work together. Questioning investigated any changes to  
239 decisions since assessment or new decisions, the extent to which these were viewed  
240 as shared previously or upon change, as well as the relevance and importance of  
241 these decisions. Questioning also included subtle decisions such as participation in  
242 extra-therapeutic activities or discussion topics within treatment sessions.

### 243 **Reflexive considerations.**

244 In terms of biases, all authors had an interest in, and favourable attitude  
245 towards, SDM practices in psychotherapy. To control for this, we selected methods  
246 that we felt were least amenable to unintentional bias. For example, we adopted a  
247 grounded theory approach which starts with creating categories that are descriptive  
248 and based on clients' reports, rather than researcher interpretations.<sup>42</sup> In addition,  
249 coming from a pluralistic epistemological standpoint,<sup>43</sup> we were committed to  
250 maintaining a critical and reflexive stance towards our own assumptions, and an  
251 openness to new and unexpected findings.

### 252 **Analytical method**

253 Transcripts from both IPR and supplementary interviews were analysed using  
254 a grounded theory approach adapted for psychotherapy research.<sup>42</sup> Rennie et al.'s  
255 method is informed by Glaser and Strauss's steps for performing a grounded theory  
256 analysis, consisting of data collection, open categorising, concurrently and  
257 systematically collecting data, establishing categories, memoing, and identifying  
258 emerging patterns to determine a core category.<sup>44</sup>

259 Data from both IPR and semi-structured interviews were analysed together,  
260 except when a distinction between the two time points was considered meaningful  
261 due to working towards a comprehensive grounded theory, rather than individual

262 thematic categories. For example, when clients offered a new perspective on a  
263 decision in their supplementary interview that they had not mentioned in their IPR  
264 interview, this distinction is made clear. The researcher coded 819 meaning units  
265 across the 14 transcripts. These meaning units were used to build a framework of  
266 sub-components and subsequent categories that contributed to a single core category.  
267 The authors prioritised grounded theory analytical conventions over strict IPR  
268 analysis procedures.

269 Coded meaning units contributing to each sub-component and category were  
270 not from exclusive groups of clients or audio units. Therefore, single meaning units  
271 of text could be included in more than one category. For example, a client could  
272 have perceived the decision-making process within separate audio units from the  
273 same session as shared, shared and led more by themselves, or shared and led more  
274 by their psychotherapist. The number of meaning units for each category sub-  
275 component across clients can be seen in Table 1.

## 276 **Results**

### 277 **Categories and Sub-components**

278 Six categories and sub-components included coded meaning units from both  
279 IPR and supplementary interviews. The exception was the category *Daunting for*  
280 *clients to be asked to take part in decision discussions* as this contained client  
281 observations from IPR interviews only. Categories are presented in order of  
282 descending frequency, with sub-components to each category presented in kind.

### 283 **Experiencing Decisions as Shared**

284 Client descriptions of the decisions made by themselves and their  
285 psychotherapists were coded as either “shared”, “therapist led”, or “client led”. A  
286 majority of client descriptions were coded as “shared” psychotherapist ( $n=193$  text  
287 units), with all clients describing at least one decision in this way. “Shared”  
288 decisions were further broken down into “Shared equally by psychotherapist and

289 client” (n=96), “Shared, but more psychotherapist led” (n=83), and “Shared, but  
290 more client led” (n=14). For example, one client during IPR interview observed the  
291 following audio unit from their assessment session as shared equally between both  
292 themselves and their psychotherapist. Here, the dyad were finalising a therapy goal:

293 *Psychotherapist:* It’s difficult to- I can hear it’s kind of difficult to describe  
294 isn’t it?

295 *Client:* Mmm, mhm.

296 *Psychotherapist:* It’s difficult to find the exact words but I do I can picture it.

297 *Client:* It’s the doing. Yeah, the doing doing doing doing doing.

298 *Psychotherapist:* I can picture that doing slightly ac- very active. Slightly  
299 obsessive isn’t it?

300 *Client:* Mhm.

301 *Psychotherapist:* Kind of like, a bit stuck in to-

302 *Client:* -yeah.

303 *Psychotherapist:* I’ve got to do it, I’ve got to do it.

304 *Client:* Yeah, Yeah. Yeah. Yeah, it’s obsessive more than. Like could be a  
305 little, compulsive. But I think it’s more like- can’t think of the word.

306 *Psychotherapist:* Excessive.

307 *Client:* Yeah

308 *Psychotherapist:* Well that seems a good way of phrasing it, in terms of saying  
309 why-

310 *Client:* -yeah, I think that’s perfect.

311 *Psychotherapist:* Yeah?

312 *Client:* That makes sense at least. For me.

313 *Psychotherapist:* So, to understand why I go to a place of excessive, doing-

314 *Client:* -of excessive doing.

315 Table 2 shows the number of times each type of decision was coded, across  
316 clients. Moments of shared decision-making from this data have been examined by  
317 speaking turn using Conversation Analysis in a subsequent study. <sup>6 45</sup>

318           **Therapists supporting clients to become more active in the decision-**  
319           **making process.**

320           All clients felt that their psychotherapists encouraged and supported their  
321 activity in decision discussions, and that this facilitated the SDM process. All clients  
322 reported this encouragement and support in at least one decision discussion with  
323 their psychotherapist. These clients observed this support occurring across four  
324 actions, coded as four sub-components.

325           *Helping clients to articulate opinions, suggestions and wants.*

326           All clients felt their psychotherapists, in at least one decision discussion,  
327 helped them articulate their opinions, suggestions and wants. This guidance often  
328 occurred when clients were uncertain how to define their treatment wants or goals:  
329 “It was obvious that I wanted to feel better, so that’s not really a useful answer either  
330 so erm, yeah, [Psychotherapist] helped me to say what it is practically that I want to  
331 change” (Client A, IPR). Eight clients felt this guiding extended to their  
332 psychotherapist offering suggestions based on what that client had spoken about.

333           *Explicitly inviting clients to contribute.*

334           Thirteen clients saw their psychotherapist as inviting them to make  
335 contributions to decision discussions. These invitations were more explicit than  
336 psychotherapists *providing opportunities for client input, or helping clients to*  
337 *articulate opinions, suggestions, and wants.* Clients felt their psychotherapists  
338 facilitated their involvement through offering encouraging prompts: “nudged me into  
339 writing it a bit, more than outrightly saying ‘we should do this’” (Client L, IPR). In  
340 addition to verbal invitations, seven clients described formal decision tools as an  
341 easier way to present their views in decision discussions “Writing it down and then  
342 talking about it was much easier than actually having to directly say” (Client D,  
343 supplementary interviews).

344           *Acknowledging clients’ expressed preferences, opinions and suggestions.*

345           Seven clients reported instances of their psychotherapists acknowledging  
346 their contributions and reassuring them of the appropriateness of making those  
347 contributions: “[Psychotherapist] kind of reassured me that, like, it’s okay to make  
348 decisions like that and to know what you want out of counselling. So  
349 [Psychotherapist] helped me to be able to express my opinions and things” (Client H,  
350 IPR). This acknowledgement and reassurance occurred whether the client  
351 contribution came from the psychotherapist helping to articulate an opinion or  
352 suggestion, an explicit invitation, or a psychotherapist-provided opportunity for  
353 input. All of these clients saw this acknowledgement as useful for facilitating shared  
354 decision discussions and for encouraging participation in future discussions.

355           ***Providing opportunities for client input.***

356           Three clients reported that their psychotherapists provided opportunities for  
357 them to have input in decision discussions: “I wasn’t being pushed in any  
358 direction... Allowed a space for me to come to more of a decision I guess, than if  
359 [Psychotherapist] had been more decisive and I felt more- less able” (Client G,  
360 supplementary interview). Other clients felt this space was provided them with  
361 opportunity for contributing more of their ideas to discussions: “But then  
362 [Psychotherapist] would let me expand where I needed to and prompted further into  
363 some things and let me go on in others” (Client I, IPR). These were implicit  
364 opportunities for a client to contribute rather than explicit invitations.

365           **Both parties presenting and recognising expert knowledge.**

366           Thirteen clients experienced both themselves and their psychotherapists as  
367 sharing specialist knowledge with each other. Clients saw this sharing as useful for  
368 facilitating decision discussions as each party learned about the client’s preferences,  
369 wants, and circumstances, as well as the psychotherapist’s expertise and professional  
370 recommendations.

371           ***Psychotherapists contributing specialist psychotherapy knowledge.***

372 Thirteen clients saw their psychotherapist as sharing specialist psychotherapy  
373 knowledge. These clients found psychotherapist suggestions to be useful for  
374 progressing decision discussions. For example, one client felt they did not have the  
375 appropriate knowledge to make suggestions in decision discussions:

376 I may be the expert, but I don't know how to apply that knowledge,  
377 [Psychotherapist] does. So, it makes sense to just kind of let  
378 [Psychotherapist] suggest stuff and me occasionally suggest stuff when  
379 I've got a better understanding of what we're talking about. (Client F,  
380 IPR).

381 *Clients demonstrating a willingness to consider psychotherapist expert*  
382 *knowledge.*

383 Thirteen clients saw themselves as demonstrating a willingness to consider  
384 psychotherapist suggestions: "I will take into consideration anything  
385 [Psychotherapist] says and anything [Psychotherapist] proposes. Because they're the  
386 psychotherapist and the psychotherapist is the person with the information" (Client  
387 G, IPR). The same client felt they wanted their psychotherapist know these  
388 intentions: "I think I would like [Psychotherapist] be aware that I am open to their  
389 suggestions. I don't want to come across as a person who's shooting down anything  
390 they've said or any ideas that [Psychotherapist] has" (Client G, IPR).

391 *Clients sharing specialist knowledge about themselves and their*  
392 *preferences.*

393 Twelve clients saw themselves as sharing specialist information about  
394 themselves that their psychotherapist did not hold. This included their wants,  
395 preferences, and details about their circumstances they felt were important to the  
396 decision discussion: "telling [Psychotherapist] my experience, how I felt, my likes  
397 and interests. And [Psychotherapist] going from that" (Client E, IPR). For one client,  
398 this included how a potential decision could impact their family and friends:

399 “Because obviously like, I know the people involved so I know what will and won’t  
400 work” (Client I, supplementary interview).

401 **Clients felt recognised as an individual and accommodated for by their**  
402 **psychotherapist.**

403 Thirteen client reports contributed to three sub-components that comprised  
404 this category.

405 *Decisions were relevant to and useful for clients.*

406 Eleven clients felt that decisions resulting from a SDM process were  
407 meaningful and relevant to themselves and their treatment: “I think it’s relevant, I  
408 mean obviously [Psychotherapist] didn’t pull it out of nowhere” (Client J, IPR). Two  
409 clients were asked during supplementary interview if this relevance remained, and  
410 both agreed it had. Five clients felt these decisions were important for what they  
411 wanted to achieve in psychotherapy: “Because like at the very beginning I was just  
412 starting to realise that that was a major issue for me” (Client C, IPR). Other clients  
413 felt these decisions made their psychotherapy wants feel achievable: “They’re quite-  
414 quite achievable. And this is a good idea.” (Client A, supplementary interview).

415 *Clients, their preferences, and their wants were accommodated for.*

416 Eight clients reported that psychotherapist actions led them to feel their  
417 preferences and wants were accommodated for in the decision-making process. For  
418 example, by a psychotherapist drawing on a client’s previously discussed  
419 difficulties: “I find it interesting that [Psychotherapist] brought that up but it’s there.  
420 It’s definitely there. And I know I talked about it” (Client E, IPR). Clients felt this  
421 accommodation continued beyond assessment when deciding on psychotherapy  
422 methods for subsequent sessions: “[Psychotherapist] has been really good at just  
423 going with me in terms of where each session’s gone and just rolling with it” (Client  
424 G, supplementary interview).

425 *Listened to and understood.*



426           Seven clients reported that actions from their psychotherapist made them feel  
427 like they had been listened to and understood during decision discussions: “I could  
428 tell by what [Psychotherapist] was suggesting that [Psychotherapist] was listening to  
429 me, my actual real concerns” (Client E, IPR). This extended to clients feeling their  
430 psychotherapist had understood their psychotherapy wants: “I think everything  
431 [Psychotherapist] said there was- deeply understood perfectly how I felt” (Client G,  
432 IPR). This understanding was also true for client preferences: “it was clear that  
433 [Psychotherapist] had been listening which was quite cool, like, get my preference”  
434 (Client I, IPR).

435           **Clients felt comfortable engaging with the decision-making process.**

436           Observations and reports from eleven clients contributed to this category.  
437 These clients felt comfortable presenting their preferences: “I was comfortable there  
438 and I think because it was more of a way into the sessions as well” (Client A, IPR).  
439 One client attributed their feeling comfortable to the flexibility they saw from their  
440 psychotherapist: “I think I would say. I think because I feel [Psychotherapist] gave  
441 me so much flexibility and flexibility in terms of how I want it to go about the  
442 approach” (Client E, IPR). Four of these clients felt comfortable to challenge or  
443 reject psychotherapist suggestions if that client felt their preference was not  
444 understood.

445           In being comfortable to take part in the SDM process, six clients felt it was  
446 empowering to be involved in their treatment decisions and to have some control  
447 over them. One client reported: “It made me feel empowered, but it also then it made  
448 me feel like I was empowered by myself” (Client E, IPR).

449           **Daunting for clients to be asked to take part in decision discussions.**

450           Four clients felt psychotherapist attempts to involve them in the decision  
451 discussions were daunting:

452 I don't know. I think sort of being asked was quite daunting... But you  
453 go from sort of quite daunting like "I want support but I don't know what  
454 support". And then like, being given that small amount of support like  
455 calms you down a bit because you're being shown what support you're  
456 getting. (Client C, IPR)

457 Another client recalled a similar daunting feeling when unable to answer their  
458 psychotherapist: "not really sure at this point. So, it's kind of a like a sigh of 'Oh  
459 god, I'm being asked what else and I can't really think of anything'" (Client H, IPR).  
460 Clients reported this daunting feeling subsiding when their psychotherapist provided  
461 additional information on what the decision might mean moving forward.

#### 462 **Core Category**

463 Using grounded theory, a preliminary model emerged from the IPR and  
464 supplementary interview data to indicate how clients experienced the SDM process  
465 in pluralistic psychotherapy for depression. Drawing on the six categories and their  
466 subcomponents, the following core category was developed: "Psychotherapists  
467 encourage client participation and progressively support clients to provide  
468 information and contributions towards shared treatment decisions that could be led  
469 equally, or marginally more by one party".

470 In pluralistic psychotherapy, clients and psychotherapists hold decision  
471 discussions whereby they *present and recognise each other's expertise and*  
472 *knowledge*. When occasionally, clients have difficulty in engaging in decision  
473 discussions or it is *daunting for clients to be asked to take part in decision*  
474 *discussions, then psychotherapists progressively support clients to become more*  
475 *active in the decision-making process*. However, psychotherapists also offer such  
476 support when clients are comfortable taking part in decision discussion.  
477 Consequentially, *clients feel comfortable engaging with the decision-making process*  
478 *and feel recognised as an individual and accommodated for by their psychotherapist*.

479 This leads clients *to experience the decisions made as shared* – although these could  
480 be led equally, or marginally more by one party. Overall, clients in pluralistic  
481 therapy experience a decision-making process in which their therapists encourage  
482 their participation, progressively support them when they had difficulty contributing  
483 to that process and draw on their expertise to offer perspectives on how the therapy  
484 might unfold. This results in a process that clients see as shared, and useful for  
485 making treatment decisions.

## 486 **Discussion**

487 Most psychotherapy clients felt comfortable engaging in the SDM process.  
488 These findings are similar to those from general healthcare that have shown patients  
489 to be comfortable in taking part in SDM interventions before treatment.<sup>46</sup> However,  
490 psychotherapy clients also reported instances where it was daunting to take part in  
491 decision discussions. These reports were in a minority of instances, for a minority of  
492 clients; but they are important for a holistic understanding of clients' experiences of  
493 SDM. It also helps to fulfil the standards of validation for a grounded theory:  
494 presenting a comprehensive account that provides generality by being inclusive of  
495 variation and applicable to a range of contexts.<sup>44 47</sup>

496 The present analysis offers new findings to show SDM can be a positive  
497 experience for clients and their treatment in psychotherapy. Clients felt they were  
498 listened to and understood, had their needs and preferences accommodated for, and  
499 that the resulting decisions were relevant for themselves and their psychotherapy.  
500 These reports share similarities with healthcare patients that felt their shared  
501 decisions were relevant, helpful, and useful for themselves and their treatment.<sup>46</sup> The  
502 present client reports also share similarities with patients who felt satisfied with their  
503 shared treatment decision-making.<sup>14</sup> Together, these findings suggest that  
504 psychotherapy clients generally have a positive experience of taking part in SDM.  
505 Moreover, the similarities between the psychotherapy and general healthcare

506 experiences of SDM imply that the approach has a potential positive impact across  
507 the helping professions.

508 Therapists encouraging and supporting clients—from providing opportunities  
509 for client input to explicit invitations—was found to be useful for facilitating SDM.  
510 This finding is consistent with Henselmans et al.'s reports of patients offering  
511 further preference talking following oncologist empathy, checking questions, and  
512 preference reflections.<sup>17</sup> However, clients in the present analysis felt that their  
513 psychotherapist providing additional information helped ease the feeling that taking  
514 part in decision discussions was daunting. We also found that the use of formal  
515 feedback tools may assist clients who want to take part in decisions but are daunted  
516 by the task.

517 Clients felt that both parties presenting their specialist knowledge helped  
518 facilitate SDM. This suggests that the SDM clients experienced in the present  
519 integrative psychotherapy is aligned with formal recommendations for SDM  
520 practice. For example, that practitioners should contribute their professional  
521 knowledge and clients should communicate their ideas, values, and preferences, with  
522 both parties contextualising this information to the client and their difficulties.<sup>1 48 49</sup>  
523<sup>50</sup> Moreover, the present analysis offers new findings to show that clients found their  
524 own willingness to consider psychotherapist suggestions as helping to facilitate  
525 SDM.

### 526 **Study limitations**

527 Three clients were unable to take part in supplementary interviews following  
528 their fourth treatment session. This was due to unplanned treatment endings and  
529 limited client availability. However, categories began to saturate at the eleventh  
530 participant, suggesting that much of the variety in client experiences would be  
531 captured without this additional data.

532           There is the potential for clients to have been overtly positive in their reports  
533 of SDM. Such demand characteristics could have been present as interviews were  
534 conducted by a member of the university research clinic team, within the same clinic  
535 clients were beginning treatment in.

536           As the research was conducted within the context of an SDM-oriented  
537 psychotherapy, the findings may not be generalizable beyond such approaches. This  
538 context may also have increased demand characteristics, with clients feeling obliged  
539 to endorse practices that they knew were central to their psychotherapy. The lack of  
540 standardized training, or adherence monitoring, on SDM, also makes the present  
541 findings less easily interpretable.

542           Although this paper considers negative experiences of SDM, it does not  
543 cover data on barriers to SDM occurring, or experiences in which SDM did not take  
544 place.

#### 545 **Implications for Practice**

546           Our findings provide general support for the use of SDM in psychotherapy.  
547 However, we found that SDM could be experienced as being shared without an exact  
548 equivalence of inputs from psychotherapist and client. This suggests that  
549 psychotherapists should consider SDM a gradient phenomenon, rather than an “all-  
550 or-nothing” threshold one, in which levels of sharedness in decision-making can be  
551 varied depending on the particular circumstances. In addition, our findings suggest  
552 that psychotherapists can play an active role in facilitating the SDM process through  
553 providing opportunities for client input, explicitly inviting client contributions,  
554 helping clients articulate their preferences, and acknowledging clients’ contributions  
555 to the SDM process. In addition, while clients’ recognised their own contributions to  
556 SDM; they also demonstrated an openness, and desire, for psychotherapist expert  
557 input.

558           The present analysis, however, also indicated that some psychotherapy  
559 clients can be daunted by SDM practices. We found that, while some clients wanted  
560 to be fully involved in decision-making, others wanted the psychotherapist to take  
561 the lead. This corroborates findings from the healthcare literature that suggest that  
562 not all clients may want to be involved in their healthcare decisions. On this basis,  
563 Towle and Godolphin suggested physicians should elicit patient preferences for  
564 involvement, as well as for amount and format of information.<sup>50</sup> Similarly, Borrell-  
565 Carrio et al. suggest that offering the patient the option of more or less autonomy  
566 may be ideal practice;<sup>51</sup> and O'Connor et al. have designed decision-aids to elicit  
567 the amount of involvement clients want to have when sharing decisions.<sup>52 53</sup> Such  
568 practices may be transferable to the psychotherapeutic context, such that the degree  
569 of tailoring, itself, can be tailored to the individual client.

#### 570 **Implications for Further Research**

571           The present analysis provides an understanding of client experiences of  
572 SDM, although other methods could offer additional perspectives. Doing so would  
573 move the field closer towards a holistic understanding of SDM in psychotherapy. For  
574 example, researchers could use IPR interviewing and a grounded theory approach to  
575 investigate psychotherapists' experiences of SDM. Such an analysis would be  
576 directly comparable to the present analysis. Gaining psychotherapist perspectives  
577 would also be useful to understand any gaps between clients and psychotherapists  
578 perceptions of leadership in SDM, as previous findings showed perceptions of  
579 decision-making leadership can differ between patients and practitioners.<sup>54</sup> Second,  
580 the use of ethnomethodology or conversation analysis could examine SDM as it  
581 occurs *in situ*. Conversation analysis would offer a third, objective perspective  
582 outside clients and psychotherapists views. In all such studies, standardized  
583 delivery—and monitoring—of SDM practices would help to enhance the  
584 interpretability of findings.

585

#### **Conclusion**

586           Our study found that, in most instances, clients were comfortable taking part  
587 in shared decision-making and had positive experiences. Most clients found their  
588 psychotherapists' encouragement and support helpful in facilitating this process,  
589 particularly when they were having difficulties contributing. Our findings also  
590 suggest that psychotherapy clients may have different preferences for how much  
591 involvement they want to have in their treatment decisions. Therefore,  
592 psychotherapists practicing shared decision-making should strive to be aware of  
593 these potential differences in preferences and recognise that decision-making can  
594 remain shared even if led more by themselves or their clients.  
595

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- 743

Table 1

*Coded meaning units contributing across interviews and clients*

	Meaning units (Clients)		
	All	IPR	Su Inter
<i>Experiencing Decisions as Shared</i>	193 (14)	136 (14)	57
Shared, but more psychotherapist-led decision-making	83 (13)	59 (13)	24
Shared leadership over the decision-making process	96 (12)	64 (11)	32
Shared, but more client-led decision-making	14 (4)	13 (4)	1 (
<i>Therapists supporting clients to become more active in the decision-making process</i>	320 (14)	262 (14)	58
Helping clients to articulate opinions, suggestions and wants	122 (14)	97 (14)	25
Explicitly inviting clients to contribute	152 (13)	125 (13)	27
Acknowledging clients' expressed opinions, preferences and suggestions	41 (7)	37 (7)	4 (
Providing opportunities for clients' input	5 (3)	3 (2)	2 (
<i>Both parties presenting and recognising expert knowledge</i>	197 (13)	123 (13)	74
Therapists contributing specialist psychotherapy knowledge	113 (13)	69 (13)	44
Clients demonstrating a willingness to consider the psychotherapist's expert knowledge	44 (13)	22 (9)	22
Clients sharing specialist knowledge about themselves and their preferences	40 (12)	32 (12)	8 (
<i>Clients felt recognised as an individual and accommodated for by their psychotherapist</i>	117 (12)	69 (12)	48
Decisions were relevant to and useful for clients	64 (10)	26 (9)	38
Clients, their preferences, and their wants were accommodated for	38 (8)	29 (8)	9 (
Listened to and understood	15 (7)	14 (7)	1 (
<i>Clients felt comfortable engaging with the decision-making process</i>	70 (11)	55 (11)	15

744

745

Table 2

*Amount of coded descriptions from clients across different decision-making leadership styles.*

	Clients	Coded meaning units
Therapist-led (non-shared)	12	37
Shared, but more psychotherapist led	13	83
Shared equally by psychotherapist and client	12	96
Shared, but more client led	4	14
Client-led (non-shared)	10	40