**Consultation Interactions Coding Scheme (CICS) 1.6**

**- Away from Change**

**-** Low Patient Activation

**- Towards Change**

**-** High Patient Activation

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**Background** [(Return to top)](#Contents)

Previous literature has found that certain types of healthcare interaction contribute to improved health outcome more than others ([e.g. Moyers, Martin, Houck, Christopher, & Tonigan, 2009](#_ENREF_8)). Patient activation is an identified contributor to improved health outcomes, particularly in long-term or comorbid health issues, but its impact has not been explored at an interaction level ([Greene, Hibbard, Sacks, Overton, & Parrotta, 2015](#_ENREF_3); [Mosen et al., 2007](#_ENREF_7); [Schmaderer, Zimmerman, Hertzog, Pozehl, & Paulman, 2016](#_ENREF_10)). Patient activation is a recognised concept focused on the knowledge, skills and confidence a person has in their ability to be involved in and manage their health ([Hibbard, Stockard, Mahoney, & Tusler, 2004](#_ENREF_4)). This coding manual categorises different interaction topics or themes and uses patient activation to characterise the types of interaction that may contribute to improved outcomes and those that contribute to non-improvement or deterioration.

The themes used in this manual are derived from a thematic analysis of 22 transcripts of Cognitive Behaviour Therapy (CBT) provided to 11 patients in a case-series study of CBT for long-term high utilisers of primary care ([Malins et al., 2016](#_ENREF_5)). Multimorbidity was identified as a key feature of the problems experienced by this patient group ([Patel et al., 2015](#_ENREF_9)). Patient activation and interaction-style in clinical consultations have been identified as effective intervention routes for people experiencing multiple, chronic physical and mental health problems where targeted treatments are difficult to select and apply. ([Deen, Lu, Rothstein, Santana, & Gold, 2011](#_ENREF_1); [Derksen, Bensing, & Lagro-Janssen, 2013](#_ENREF_2); [Mercer, Gunn, Bower, Wyke, & Guthrie, 2012](#_ENREF_6)).

For each participant a session from the earlier half and latter half of therapy was randomly selected. An inductive thematic analysis was conducted by two coders working independently, using transcripts of the selected sessions. Whilst blind to participant outcomes, a theory-informed deductive analysis was then carried out. Patient activation theory was used to establish interaction types most likely to contribute to outcome. This resulted in a process model of themes grouped into three categories: Theme presentations likely to contribute to: (1) therapeutic improvement; (2) non-improvement or deterioration; and theme presentations where (3) no clear distinction could be made.

This manual is used to categorise the interactions in psychological therapy sessions on the basis of patient activation. The coding process is described below, followed by descriptions of each theme, a coding summary sheet (Appendix 1) and a code scoring sheet (Appendix 2).This manual does not aim to be used as a standalone method of training coders, but is to be used in conjunction with guided coding sessions led by experienced coders, as described in the training process below.

**Guidance for Coders** [(Return to top)](#Contents)

**Coding Terms**

**Turn -** A patient or therapist turn of speech, which continues until the other person begins speaking instead.

**Segment** – A session extract to be coded. This could include a single turn or several turns.

**Theme** - The overall topic of interaction which will be coded. Each is described in “[Session content themes](#Session_Segment_Themes)” (p15) and “[Global themes](#GlobalThemes)” (p26). Themes are rated at different levels of patient activation. When a specific theme and level is applied to a particular session segment it is “coded”.

**Coder Training**

Code six transcripts in three sets pairs with two hour training sessions between each pair. These transcripts are benchmarked “gold standard” transcripts coded by at least two experienced coders where themes and levels were jointly agreed. Inter-rater reliability is deemed to be achieved when an overall Intra-class correlation coefficient of 0.7 or above is achieved across all themes and levels. Further transcripts are coded if necessary.

**Coding Levels**

Coding a session using this manual requires session recordings transcribed verbatim. Audio-visual recordings support and enhance coding, but are not required. First code the transcript using [session content themes](#Session_Segment_Themes) – note turns of speech where each theme is present. All themes are rated on one of five levels ranging from +2 to -2. There are two levels for what are deemed to be therapeutically positive interaction types (i.e. moving towards therapeutic change), graded +1 and +2. There are two levels for what are deemed to be therapeutically negative interaction types (i.e. moving away from therapeutic change), graded -1 and -2. Between them lies a neutral level (coded as 0). When coding an extract, begin at 0/neutral and move up or down if sufficient observable evidence is present to warrant doing so. Use 0/neutral as the default position or if the polarity is unclear. Each level is characterised in a similar fashion across themes, broadly focused on the level of patient activation:

***+2***: Hypothesised to be the optimal therapeutic interaction type within the theme. Key attributes are a high level of patient activation and focus; a therapeutic interaction or activity *led by the patient without an explicit invitation or elicitation* from the foregoing therapist turn-of-speech*.*

**Example 1**

|  |  |
| --- | --- |
| **Therapist:** How is your family life?**Patient:** Well, I’ve realised something that would help us all. I’ve decided that it’s really important for me to start running again. I used to run all the time and it was really helpful. **Therapist:** Great idea! When could you start? | Action Planning & Idea Generation, +2 |

***+1***: Hypothesised to be a positive interaction, but with a lower level of patient activation and leadership. Typically this would be a positive interaction led or guided by the therapist, which the patient is both endorsing and developing. A +2 levelinteraction would be differentiated because it would be patient-led interaction *not directly responding to the previous therapist* interaction*.*

**Example 2**

|  |  |
| --- | --- |
| **Therapist:** What about starting running again? You used to enjoy that.**Patient:** Yes, I’d been thinking that too. Maybe I could do it in the morning before work. | Action Planning & Idea Generation, +1 |

***0*** ***(Neutral)***: These are interaction where *few discernible positive or negative interactive factors* are apparent and is deemed to be neutral. This includes interactions where therapists make suggestions or comments with little observable sign of how the comment has been received and limited receptivity on the patient’s part.

**Example 3**

|  |  |
| --- | --- |
| **Therapist:** What about starting running again? You used to enjoy that.**Patient:** Maybe.**Therapist:** You could start tomorrow morning.**Patient:** Yeah. | Action Planning & Idea Generation, 0 |

***-1****:* Hypothesised to be interactions that are therapeutically unhelpful in a minor way. This includes interactions which show the beginnings *of unaddressed disagreements or reluctance to engage* with therapeutic activities. Low levels of patient activation and involvement are observable, independent of therapist activity.

**Example 4**

|  |  |
| --- | --- |
| **Therapist:** What about starting running again? You used to enjoy that.**Patient:** I’m not sure that would work.**Therapist:** You could start tomorrow.**Patient:** I doubt it. | Action Planning & Idea Generation, -1 |

***-2****:* Hypothesised to be interactions that would be contradictory to most therapeutic guidance. This would include argumentative or obstructive interactions where the patient (and potentially the therapist) appear(s) *disengaged and/or unfocused and/or oppositional* to therapeutic activity.

**Example 5**

|  |  |
| --- | --- |
| **Therapist:** What about starting running again? You used to enjoy that.**Patient:** That’s a terrible idea. You clearly don’t understand me.**Therapist:** Maybe if you got off the couch and did something you wouldn’t be so negative.**Patient:** That has nothing to do with it! | Action Planning & Idea Generation, -2 |

The overall approach to coding levels can be illustrated pictorially as below. The level coded is a proxy for the level of patient activation and orientation to change that can be inferred from the segment under review. A level of 0 would denote an interaction where neither movement towards or away from change can be observed nor is there sufficient observable evidence to say that the patient is either activated or disengaged. Positive levels indicate increasing evidence of movement towards change and active therapeutic engagement. Conversely, negative levels indicate increasing movement away from change and disengagement.

**- Away from Change**

**-** Low Patient Activation

**- Towards Change**

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****    ****

 **-2 -1 0 +1 +2**

Apply the level that seems the best fit for the extract under review. Where applicable, the key component for the level of each theme is displayed in *italics* to emphasise its significance.

After coding session content themes:

1. Focus on the [global scales](#GlobalThemes). Allocate the level that is the best fit for the transcript as whole, although there are likely to be deviations from this at points in the session.
2. Review codes that have already been allocated, with knowledge of the context of the whole session. You may wish to add or remove themes that were not apparent in the first pass. This is most likely to happen in large extracts where one theme of the same level was recorded. Some of the *levels* coded may also need readjusting.

Themes can be coded concurrently at the coder’s discretion. In particular, *Problem analysis and understanding (PAU)*, *Noticing change or otherwise (NCO)* and *Structuring and Task Focus (STF)* codes are likely to be coded concurrently with other themes.

Before coding any sessions, coders should familiarise themselves with each theme and the relevant level descriptors. A theme summary sheet is provided at the end of this manual which can be used as an ongoing reference whilst coding (Appendix 1).

**Segmenting** [(Return to top)](#Contents)

Apply at least one theme at a specific level to each turn of speech from the therapist and patient. A single theme and level is coded for as long as it is the best fit for the segment. This can incorporate several patient and therapist turns.

**Example 7**

|  |  |
| --- | --- |
| ***Therapist*:** So when we stay with something that makes us anxious, over time, we often find the anxiety starts to fade as we get used to it. ***Patient*:** That makes sense, because eventually I just forgot all about that rash. |  Information Discussion, +1 |

Longer turns may be coded with more than one theme or a change in the theme level. This is particularly likely with the *PCD* theme.

**Example 8**

|  |  |
| --- | --- |
| ***Patient*:** At times I end up searching the internet to see what’s wrong, it’s really bad and I just get myself so worried. I’m strong enough to beat this though; I know I’m going to get there. | Problem or Context Descriptionevaluation of self or therapy, +2 |

Small interjections of one theme within an extract clearly linked to another theme may be omitted.

|  |  |
| --- | --- |
| ***Therapist:*** Have you noticed any changes in your mood?***Patient:*** I am feeling a bit better I think since we started meeting. I have still got this niggling pain in my neck that won’t go away and I’m not sure what to do about it, but on the whole things are definitely better.**Therapist:** What do you think has brought this change about? | Noticing Change or Otherwise, +1(not coded) Problem or Context Description  |

**Example 9**

In Example 9 where a patient is prompted to talk about changes they have noticed, the NCO theme would be applied at the +1 level. There is a small interjection which on its own would be coded under *PCD* (underlined) but this does little to disrupt the overall flow of the existing theme and so is not coded. Furthermore, the therapist response is focused on the NCO theme.

In Example 10 the *NCO* theme is clearly stopped and the *PCD* theme is started, which should be an additional code for that turn. In particular, the change in theme is emphasised by the fact that the next turn responds to the problem description rather than the change that has been noticed.

**Example 10**

|  |  |
| --- | --- |
| ***Therapist:*** Have you noticed any changes in your mood?***Patient:*** I am feeling a bit better I think since we started meeting. I have still got this niggling pain in my neck that won’t go away and I’m not sure what to do about it. It’s dragging me down.**Therapist:** That does sound bad, tell me about the pain | Noticing Change or Otherwise, +1Problem or Context Description |

If two themes are apparently present in one turn the turn is split and coded with each theme. The level of the theme is determined by the response it receives. If a theme is ignored, the level coded is 0.

|  |  |
| --- | --- |
| ***Therapist:*** I want to explain something about vicious cycles in panic attacks: Noticing that your heart is racing can make you worried about what it means, but this worry makes your heart race more. So I think that we will try some techniques to help you get used to the feeling of your heart racing.***Patient:*** Some techniques to help with my heart racing would be really useful, because that is a real problem for me. | Information Discussion, 0Action Planning & Idea Generation, +1 |

**Example 11**

In this example the therapist turn begins with a segment which is clearly within the *Information Discussion (IDI)* theme. However, it transitions to an *Action Planning and Idea Generation (API)* theme. The coding decision relies on the patient’s response. The patient responds to the *API* component over the *IDI* component therefore the *IDI* theme is coded at level 0 as there is no clear response from which to judge it. The *API* theme is coded at +1 level as there is a positive developing response.

 **Facilitative language.** Where there are segments that do not seem to apply to any particular theme, but are mainly facilitative in nature they are coded at the same theme and level as the preceding segment:

|  |  |
| --- | --- |
| ***Patient:*** I have been suffering with this problem for several years now without any change.**Therapist:** Seven years?**Patient:** No several years.**Therapist:** Several?**Patient:** Yeah.**Therapist:** Ok, sorry. | Problem or Context Description |

**Example 12**

 **Returning to neutral.** Where a segment is being coded at either a positive (level +1 and +2) or a negative level (-2 and -1) of a particular theme there are likely to be occurrences where coding needs to return to neutral (0).

|  |  |
| --- | --- |
| **Therapist:** It sounds like you see things differently now.**Patient:** Absolutely, I can see that I was wearing myself out and beating myself up when I would have been able to achieve more if I had paced my activity.**Therapist:** Yes, to stop when you’ve done enough for your body.**Patient:** Yes.**Therapist:** And accept that you can’t do it all at once.**Patient:** Yeah.**Therapist:** Because that makes it worse**Patient:** That’s right and what I can do is perfectly normal for a man of my age. I sometimes expect myself to work like a 20 year old!**Therapist:** You were expecting too much of yourself. | Problem Analysis & Understanding, +1Problem Analysis & Understanding, 0Problem Analysis & Understanding, +1 |

**Example 13**

Example 13 begins with two turns coded as *PAU, +1* because the patient provides development of their understanding cued by the therapist. The underlined segment is a return to *PAU, 0* because there is no patient development of the analysis presented by the therapist for these turns. Then there is further development later on so the level returns to *PAU, +1.*

 **Stepping up from +1 to +2.** For there to be a step up from +1 to +2 there needs to have been a deviation from the topic (typically by the therapist) to allow the patient to initiate a new segment in its own right as +2.

|  |  |
| --- | --- |
| **Therapist:** So how about if you started off by only checking the internet once a day?**Patient:** Ok, yeah so for maybe ten minutes.**Therapist:** And we’ll see how you got on next week**Patient:** Yeah, ok.**Therapist:** Great.**Patient:** Also**,** I’ve actually had a new idea about how to tell my boss not to put so much pressure on me. I’m going to arrange a meeting and then ask her how she feels first.**Therapist:** Brilliant idea! When are you thinking of doing that? | Action Planning & Idea Generation, +1Action Planning & Idea Generation, 0Action Planning & Idea Generation, +2 |

**Example 14**

In the example above, the action planning starts by being guided by the therapist, but there is a clear break to a level 0 and a clear restart initiated by the patient. Hence the last segment is coded at the +2 level.

**Decision Tree** [(Return to top)](#Contents)

Coding involves a three stage decision-making process:

1. Which theme shall I code for the current segment?
2. Is there enough evidence for the level coded to be either above or below level 0? (0/neutral is the default code).
3. If yes, to what degree is the current segment positive (+1 or +2) / negative (-2 or -1).

Therefore, a coder first decides which of the session content themes should be coded for the current segment, then decides whether it demonstrates sufficient difference from neutral to warrant a positive or negative valence and finally a decision is made about the degree to which it demonstrates a positive or negative valence. Overall, coders apply the level that is the best fit, but if there is a lack of clarity the more conservative score is given (i.e. +1 instead of +2 if unsure).

**Decision-Tree Example:**

|  |
| --- |
| **Therapist:** It seems like things are really different now, you’ve done well.**Patient:** Hmm, I’m not so sure about that, it’s still pretty rough. |

1. **Which Theme?**

Structuring and Task Focus

Information Discussion

Problem or Context Description

Problem Analysis and Understanding

**Noticing Change or Otherwise**

Action Planning, Idea generation

Evaluations of Self or Therapy

1. **Evidence of positive or negative valence?**

**YES, Negative**

YES, Positive

NO, Neutral

1. **To what degree is it negative? (use level descriptors to decide)**
2. To what degree is it positive? (use level descriptors to decide)

*Allocate neutral code:*

*NCO, 0*

**LOWER LEVEL**

HIGHER LEVEL

***Allocate lower level negative code: NCO, -1***

Allocate higher level negative code: NCO, -2

**Decision Rules for Theme Choice** [(Return to top)](#Contents)

Two rules are applied in deciding which theme is most appropriate for a particular segment:

**Primary Rule:** Could the segment stand alone, independent of the context, and still be identified correctly by the theme definition and level descriptor? If a clear theme and level cannot be achieved using this rule, the secondary rule should be applied.

**Secondary** **Rule:** Which themeis the best fit for this segment given the context, before and after it occurs? This would include themes and levels applied 2-3 turns before the segment and 2-3 turns after the segment. If still unclear a different code should be considered – PCD being the most common in areas of doubt.

**Example 15**

|  |  |
| --- | --- |
| ***Therapist*:** When you stop checking your body you’re less bothered by pain and worries.***Patient*:** Yes, it was keeping me worried when I thought it was helping. | Information Discussion, +1**OR**Problem Analysis & Understanding, +1 |

When the segment in this example is seen independent of context it seems that two themes could be coded: *IDI* or *PAU.* To decide between these two the broader context is reviewed:

|  |  |
| --- | --- |
| ***Therapist:*** So you tried an experiment this week to see what happened if you didn’t check your body for a week. How did it go?***Patient:*** It was so different I can’t believe it. By the end of the week I was hardly thinking about the pain in my stomach at all! I hadn’t realised checking was making me anxious!***Therapist*:** When you stop checking your body you’re less bothered by pain and worries.***Patient*:** Yes, it was keeping me worried when I thought it was helping. | Noticing Change or Otherwise, +1**AND** Problem Analysis & Understanding, +1Problem Analysis & Understanding +1 |

With the context of the previous two turns it becomes clear that this is not a situation where the therapist is offering new information, but is summarising the new understanding that the patient has reached from the experiment tried between sessions. As such, the segment is coded as *PAU, +1*.

**Scoring** [(Return to top)](#Contents)

Scoring aims to summarise an overall picture of the spread of themes and levels present across a segment or session. It provides a visual and analytical impression of how much of the session was spent in interactions that were positively coded or otherwise.

Multiply the proportion of the transcript coded at each level of each theme by the score for the given level (TOTAL 1). For example, if 10% of a transcript was coded as Action Planning and Idea generation (API) at the +2 level, this would contribute a score of 20 to the total for the API theme (+2 x 10). Conversely, if 10% of the same transcript was scored as API -1, this would contribute a score of -10 to the total for the API theme (-1 x 10). If these were the only levels of API coded for the transcript a total score for API on that transcript would be 10 (20-10). To calculate overall content scores, average the scores for each theme (TOTAL 2). Global themes are scored separately with a single rating on the level scored.

NVivo 12 coding software can be used manage transcript data and to give the percentage of a transcript coded at a given theme level.

**Implications**

From coding scores, outcome can be predicted. This is based on the proportion of the transcript coded at high levels as opposed to neutral or low levels. If specific themes and/or rating levels predict health outcomes this would give therapeutically valuable feedback to therapists on the relationship between patient outcome and specific interactions types. As such the coding manual could be used to develop skills for therapists in training, as well as helping refine skills and enhance outcome for those in practice.

**Session CONTENT themes** [(Return to top)](#Contents)

Session content theme definitions and level descriptors are given below.

**Action Planning and Idea Generation (API)** [(Return to top)](#Contents)

Coded where either party suggests an action plan or potential problem solution idea linked to activities which might take place *outside the session*. The level coded is dependent on how the idea is developed or refined and the degree of observable engagement, particularly from the patient. The refinement of ideas may stray into what seems like a PCD theme, as the barriers to actions are discussed. This should be coded as PCD and return to API if further action planning is restarted. If the rationale for a particular action is given but no explicit suggestion is made that it could be done then this should be coded as IDI. For actions that are planned to be completed in the session use the STF theme.

|  |  |
| --- | --- |
| ***Patient:*** I want to build up my fitness so I can do more things with the family, but I know I’ll have to pace myself and build it up over time.***Therapist:*** Where would you want to start with that?***Patient:*** I was thinking that I could be doing more walking than I have been doing. I get the bus into town, and I could maybe walk to the next stop along from where I normally catch it. | API, +2 |

**+2.***Patient initiated* action plans or change ideas that have potential to be applied through refinement and discussion.

**+1.** Therapist initiated action plans or change ideas, the patient agrees with *development, summary or* *corrections.*

**0.** Therapist initiated action plans or change ideas – *no development or clear sense of patient view.*

**-1.** Therapist or patient initiated action plan or change idea – *unresolved reluctance or ambivalence expressed* by patient or therapist towards the action plan*.*

**-2.** Therapist or patient initiated action plan or change idea – *ignored, refuted or distracted to another topic* and no agreement is reached.

|  |  |
| --- | --- |
| ***Patient:*** I do find myself getting quite het up about it***Therapist:*** Next time you feel that way, you should have a go at the breathing exercises in this booklet.***Patient:*** I don’t want to do that because the other thing is that I think I’ve got the wrong eye drops, but they’ve said I’ve got to wait for a month to see how it goes. | API, -2 |

**Evaluations of Self or Therapy (EST)** [(Return to top)](#Contents)

Code where there are interactions focused on evaluating therapy and/or related activities; self-supporting statements, or instances where completion of a therapeutic task is acknowledged as an accomplishment. This also includes statements of praise or support for the therapist or patient. The level coded is dependent upon who initiates the comment and level of patient engagement and agreement. This theme is often coded alongside NCO for specific evaluative phrases.

|  |  |
| --- | --- |
| ***Patient:*** I do think this has been helpful. I’m doing things that I thought were beyond me, and getting back my confidence. | EST, +2 |

**+2.**Patient initiated statements of *self-efficacy* OR patient *acknowledgement/pride* at therapeutic achievement OR *positive evaluations* of therapy or the therapist initiated by the patient.

**+1.** Therapist initiated positive evaluation, as above, patient agrees with *development, summary or* *corrections.*

**0.** The above expressed by therapist – *ignored or* *low level acknowledgement* by the patient.

**-1.** Positive comments as above are *undermined to some degree* by patient OR *somewhat negatively focused* self-statements or statements about therapy/therapist.

**-2.** *Self-denigrating or self-critical* statements OR a *self-critical focus* on therapeutic tasks that have not been completed to the exclusion of those that have.

|  |  |
| --- | --- |
| ***Therapist:*** So you didn’t manage to complete the diary this week?***Patient:*** It’s just another example, isn’t it? I can’t do anything on my own. When I go out that door, I just mess it all up. | EST, -2 |

**Information Discussion (IDI)** [(Return to top)](#Contents)

Code where information is given or sought. The degree of relevance and reciprocity affects the level to be coded. Higher ratings demonstrate patient engagement with, and development of therapist information. Lower ratings demonstrate reluctance to engage with, or active rejection of therapist information. If information is provided by a therapist in the middle of a turn, but the patient does not directly respond to the information given then the relevant section of the therapist turn is coded as IDI, 0. This is differentiated from PAU because any information given is theoretical, abstract or general, as opposed to a personalised conceptualisation or explanation of a situation (see example 1). Key to this is the use of pronouns. Information using “we/you plural, “people” etc. would be coded as IDI. Whereas information using personal pronouns (you singular) would be coded as PAU. Segments coded as IDI contain information which could be delivered to an audience of several people and would not make sense if it was not delivered to the individual.

|  |  |
| --- | --- |
| ***Patient:*** It would be really helpful if we could talk about how panic attacks work like you mentioned last time, so I know what I’m dealing with.***Therapist:*** Yeah, great idea. Shall we look at a recent example? | IDI, +2 |

**+2**. *Patient initiated request or cue* for specific information, relevant to current therapeutic endeavour. Encouraged, endorsed or developed by the therapist.

**+1**. Therapist initiated information giving which the patient acknowledges and *develops further, summarises or seeks clarification.*

**0.** Therapist initiated information-giving - *no development* OR *development suggests unresolved misunderstanding* OR therapist acknowledges patient request for information, but does not develop.

**-1.** Therapist gives information – *patient displays ambivalence* in response OR gentle dismissal OR Information given does not seem relevant or applicable and this is clear from their responses.

**-2.** Information given that *elicits a negative response*, such as active rejection or mocking.

|  |  |
| --- | --- |
| ***Therapist:*** Let me tell you what needs to happen here. People with anxiety have got to face their fears to beat them.***Patient:*** That’s easy for you to say! If I did that I’d probably wind up worse off! | IDI, -2 |

***Problem Analysis and Understanding (PAU) and Noticing Change or Otherwise (NCO)*** *are likely to be coded in parallel. Code PAU alone where an explanation of a problem is given with no application to the patient’s life. Code NCO alone where changes are described without any explicit additional understanding. Where a change is noticed and applied to a new understanding both themes are coded.*

**Problem Analysis and Understanding (PAU)** [(Return to top)](#Contents)

Code where a new understanding is explained by either party. The level coded is dependent on the degree of reciprocity and development expressed. Higher ratings demonstrate new patient understandings, even if initiated by the therapist, that logically feed into interventions. Lower ratings demonstrate either clearly counterproductive understandings or oppositional responses to presentations of new understandings. Interactions would move from PCD ratings when questioning or descriptive interactions move to *explanatory* interactions. PAU is differentiated from IDI because any information given is personalised to the individual within a specific context, conceptualising an explanation of a situation (see example 1).

|  |  |
| --- | --- |
| ***Patient:*** I realise that I’ve been fighting myself all this time, I’ve been my own worst enemy. Trying to get away from anxiety keeps me anxious!***Therapist:*** That sounds like an important insight. How did you come to that conclusion? | PAU, +2 |

**PAU +2 *without* NCO**

**PAU +2 *with* NCO**

|  |  |
| --- | --- |
| ***Patient:*** When I looked back over the last few weeks I realised as I’ve been staying with the anxiety I’ve actually stopped feeling as anxious. It’s having a massive impact on what I can do.***Therapist:*** You’ve noticed a real difference then. | PAU, +2NCO, +2 |

***+2.*** *Patient led* articulation of a new understanding, where the solutions may be clearer (e.g. I’ve realised; I now see). There is some evidence that therapeutic concepts are understood. Endorsed or encouraged by therapist.

**+1.** Therapist initiates the above and *it is developed, summarised or corrected* by the patient OR patient-led new understanding with *limited clarity corrected, clarified, endorsed or encouraged* by therapist.

**0.** Therapist presents a problem analysis of some apparent therapeutic value and this is acknowledged by the patient with *no development* OR a new understanding is presented by either party of *little or no therapeutic value*.

**-1.** Therapist presents a problem analysis and the patient displays *ambivalence in their response without resolution*. OR the patient presents a problem analysis *with the potential to be counterproductive.*

**-2.** Therapist presents a formulation and this is *refuted by the patient. No alternative is given* and *no agreement* is reached OR the patient presents an analysis that is *anti-therapeutic* and this is not opened for correction by the therapist.

**PAU 0 *without* NCO**

|  |  |
| --- | --- |
| ***Therapist:*** So from what we’ve discussed it looks like you’re bringing these problems on yourself.***Patient:*** That’s not what’s going on. You really don’t get it do you.***Therapist:*** Look, this leaflet says the same as what I’m telling you. | PAU, -2 |

**PAU 0 *with* NCO**

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| ***Therapist:*** So you stopped seeking reassurance from your doctor and you felt less worried, maybe constantly going to him was making you anxious.***Patient:*** It’s just by chance though isn’t it? Nothing’s really change. I’m just on a lucky streak with my health. | PAU, -2NCO, -2 |

**Noticing Change or Otherwise (NCO)** [(Return to top)](#Contents)

Code where positive change (or absence thereof) is noticed and explicitly commented upon by either party. This would be linked to the patient’s efforts and/or the therapist’s efforts. This typically includes changes since therapy began but can include other patient-initiated changes without external support/prompting. The level coded depends upon the degree to which the patient notices, develops and personally owns positiveor negativechanges. If the change is extended to a meta-evaluation of the therapy or of the patient themselves it would also be coded as Evaluation of Self or Therapy (EST).

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| ***Patient:*** Last time I was waiting for test results, I just couldn’t cope. I didn’t know what to do with myself. This time though, I’ve been much better at calming myself and just getting on with the things that I’d normally be doing.***Therapist:*** Tell me more about the things you’ve been doing differently this time. | NCO, +2 |

***+2.*** Patient notices a positive change, *articulates it without prompting*. Likely to include: its impact on their life; some sense of personal ownership, or a sense of control over the change. Endorsed or encouraged by therapist.

**+1.** The above prompted by therapist – patient endorses *and summarises or develops*.

**0.** Therapist initiated acknowledgement of change - *no development* from patientOR very minor acknowledgment of change by the patient *not personally owned*, perhaps relating the change to sources outside of their control.

**-1.** Therapist initiated acknowledgement of change, *patient displays ambivalence* towards suggested change OR *Efforts to make a change are reported but none is seen*.

**-2.** Therapists initiated acknowledgement of change patient *refutes positive change*. OR Efforts to make a change are reported *but deterioration results*.

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| ***Patient:*** I guess I was hoping that things would improve, but it just isn’t happening.***Therapist:*** You say that, but I think you’ve made lots of positive changes since we started. ***Patient:*** Well, I can’t think of any, and it doesn’t feel that way. If anything, I feel like I’m going backwards. | NCO, -2 |

**Problem or Context Description (PCD)** [(Return to top)](#Contents)

Coded for apparently neutral interactions where no other theme is appropriate to be applied. This will often constitute a problem description being given or sought. It includes general assessment interactions and descriptions of the problem context, but is not limited to these topics. Levels of coding are not applied to this theme – the theme is either present or absent. The PCD theme is only stopped where there is distinct movement to a different theme. When general discussions coded as PCD deviate off relevant topics for two turns or more STF -1/-2 is coded, as it is deemed a lack of focus. If interactions totally unrelated to therapy take place Other (OTH) is coded.

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| ***Patient:*** I just find that I’m always inside the house and I feel totally trapped no matter what I do. ***Therapist:*** That sounds really tough. | PCD |

**Structuring and Task Focus (STF)** [(Return to top)](#Contents)

Code where significant changes in session direction take place, initiated by either therapist or patient. Typically, the following six turns are tracked to see if the change in direction is maintained by both parties. This theme is also coded when working through a structured task and clear instructions are being given and followed – in this case as few as one following turn can be coded. The theme includes changes of direction initiated by *drifting or deviating* from a specified topic. This may be coded alongside another theme relevant to the content of the change in direction. It includes agenda mapping that may occur at the beginning and throughout the session. Higher ratings demonstrate maintenance of a strong focus on relevant topics, endorsed, followed and/or developed by both parties. Lower ratings demonstrate unaddressed changes in focus, moving away from or seeming to avoid relevant topics; if maintained (i.e. not corrected within two turns of speech) these passages are negatively coded for the duration of the deviation regardless of number of turns. A positive code is applied if a party draws the conversation back onto relevant topics after a deviation and this is maintained.

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| ***Patient:*** I would like to start today by talking about the homework, I realised there were a few things I hadn’t understood that I’d like you to clarify.***Therapist:*** Ok, that sounds good. Which bits weren’t clear?***Patient:*** Well, I filled in the diary but I wasn’t sure if I was meant to put how I felt physically – like tired – or like worried?***Therapist:*** Would it help if went through the diary to get it clear?***Patient:*** Yeah. | STF,+2 |

**+2**. Patient *leading, cuing or initiating* a relevant session focus or task; *self-monitoring when deviating* or distracted and *redirecting* the therapist if they deviate. Structuring can still be done by therapist, but is initiated or cued by patient. This initiation is supported by the therapist.

**+1**. Therapist and patient maintaining a strong focus on a new direction which is *maintained for significant periods* *(6 turns)* or the discussion is completed. Also includes guided therapeutic tasks, to which the patient responds and follows (no specified number of turns). This can include agreeing to put off something for a later point.

**0.** Redirections and course corrections from the therapist or patient result in temporary shift of focus, *but focus is not maintained*.

**-1.** Either party drifts or deviates from relevant issues or are easily distracted onto *tangents about unrelated* *topics* *or problems*. Redirections and course corrections from either party have *little or no impact on deviating discourse*. The -1 level is coded if deviations continue for 2-4 turns of speech.

**-2.** Little or no direction provided by either party, leading to long deviations, general chat or topics that *do not lead to therapeutic activity*. The -2 level is coded if deviations continue for more than 4 turns of speech. OR A didactic style from the therapist receives an *oppositional response from the patient*.

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| ***Therapist:*** Let’s move on now***Patient:*** I want to finish what I was saying.***Therapist:*** We need to move on, we don’t have time.***Patient:*** But it’s important to me.***Therapist:*** No we need to move on. | STF,-2 |

**Other (OTH) – There may be session segments that cannot appropriately be coded using the other themes identified. In such instances, this is coded “OTH” and a brief description is given of what is observed.** [(Return to top)](#Contents)

**Global themes** [(Return to top)](#Contents)

The two scales below are rated as interaction overviews of the session as a whole. Attention should be focused on these scales after using content themes to code the whole transcript and an overall feel for the types of interactions present in the session can be given.

**Collaborative Flow (COF)** [(Return to top)](#Contents)

Assesses the extent of joint understanding and joint working displayed through the session as a whole, which may be difficult to characterise from individual incidents. At its best this is where both parties build on one another’s ideas over several exchanges (at least two contributions from each party) in a way that moves the discussion productively forward. If taken together it could almost constitute a single paragraph which could be attributed to one or other party’s speech. This is described as “collaborative flow”. Assign higher ratings for transcripts showing a more ofthis type of interaction (in quality or quantity) and lower ratings for transcripts where there is a notable absence of joint understanding or the transcript is characterised by interactions where joint working is hindered.

**+2.** There are more than three segments of collaborative flow. Collaborative flow characterises session interactions as a whole.

**+1.** There are between one and three segments of collaborative flow or several brief single episodes (one turn each) with some movement away from mutual enthusiasm, engagement and understanding at points. There is an overall sense of mutual understanding, collaboration and direction for periods, but periods where this may not be as clear.

**0.** Little or no evidence of collaborative flow.The therapeutic partnership weighs more heavily on the therapist as director and initiator. The patient may agree with the therapist’s proposals and direction, but offers little developmental contribution of their own. OR The therapist offers only agreement with the patient and little guidance or structure to develop patient input.

**-1.** There are significant periods where the patient and therapist are disconnected in their agendas or aims. There is little or no joint working in the session as a whole.

**-2.** The patient and therapist appear, to a large extent, to be talking across purposes with different agendas or goals in mind. This characterises most interactions in the session. OR the session is characterised by excessive agreement or collusion without a sense of how this agreement could move the conversation forward therapeutically.

**Integration of Themes (IOT)** [(Return to top)](#Contents)

Assesses the interconnectedness of themes and the “natural” flow or fluency between them. In positive codes multiple content themes are positively coded through the transcript and there is coherent movement between themes, with logical coverage across themes. In negative codes there is imbalance in coverage of themes, most heavily weighting on PCD with few positively coded themes.

**+2.** Significant periods of patient led fluid movement between four or more positively scored themes. Often a logically sequenced session flow.

**+1.** Some fluid movement and integration of two or three positively scored themes. Some periods where movement is limited or disjointed.

**0.** Limited integration and flow between different themes, some seemingly important themes are notably absent or ignored. Disconnected movement between unlinked themes. Limited patient involvement in movement between themes.

**-1.** Some movement between themes, but often unnatural in feel with little logical sequence. Logical gaps or inconsistencies. Very little patient involvement in navigating session themes.

**-2.** Preoccupied and disconnected focus on single themes without links with other components. Awkward or uncoordinated movement between themes. Largely therapist led with little patient cooperation.

**Refer****ences** [(Return to top)](#Contents)

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**Appendix I: Theme and level summary sheet** [(Return to top)](#Contents)

|  |  |  |  |
| --- | --- | --- | --- |
| **Theme Name** | **Theme Summary** | **+2** | **-2** |
| **Structuring & Task Focus (STF)** | Coded where significant changes in session direction take place. This includes changes of therapeutic importance or changes of direction initiated by drifting or deviating from a specified topic | Patient *leading or initiating* a relevant session focus, self-monitoring and redirecting the therapist if they deviate. | Lengthy avoidant deviations unaddressed or unabated OR Didactic, decision-making receiving little response |
| **Information Discussion (IDI)** | Code where new information is given or sought. The degree of relevance and reciprocity affect the level to be coded. When information is given that is personalised to the patient’s situation PAU is coded. | Patient initiated request for specific information, relevant to therapeutic endeavour. | Information given elicits negative response OR Information given not relevant |
| **Problem or Context Description (PCD)** | Coded for all apparently neutral interactions where no other theme is appropriate to be applied. This will often constitute a problem account being given or sought. | N/A | N/A |
| **Problem Analysis & Understanding (PAU)** | Coded where a new therapeutic understanding is described by either party. The level coded is dependent on the degree of reciprocity and development expressed. | *Patient led* new understanding with links between problem components, where the solutions follow naturally. | Therapist or patient presents a formulation and this is not acknowledged, no alternative is given and no agreement is reached. |
| **Noticing Change or Otherwise (NCO)** | Coded where positive change (or absence thereof) is noticed and explicitly commented upon by either party. This would be linked to one or more of: a) The patient’s efforts b) The therapist’s efforts. | Patient notices a positive change, articulates it without prompting. May include: its impact on their life; sense of personal ownership, or control over the change. | Therapists initiated acknowledgement of change - no patient agreement OR patient refutes positive change. |
| **Action Planning & Idea Generation (API)** | Coded where either party suggests an action plan or potential problem solution idea linked to a future action. The level coded is dependent on how the idea is developed or refined particularly by the patient. | Patient initiated action plans or change ideas that are have potential to be applied effectively through refinement and discussion. | Therapist or patient initiated action plan or change idea – *ignored, refuted or distracted to another topic* and no agreement is reached. |
| **Evaluations of Self or Therapy (EST)** | Coded where there are expressions of commitment to carry out specified tasks; self-supporting statements, or where completion of a therapeutic task is acknowledged as an accomplishment. The level coded is dependent upon who initiates the comment and level of patient development and agreement. | Patient initiated expression of commitment to therapeutic tasks OR patient statements of self-efficacy OR Patient acknowledgement of therapeutic achievement. | Self-denigrating or self-critical statements OR a self-critical focus on therapeutic task that have not been completed to the exclusion of those that have. |
| **Other (OTH)** | Coded where none of the above codes can be applied, alongside a brief description of the segment. | N/A | N/A |

**Appendix II: Theme scoring sheet** [(Return to top)](#Contents)

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| --- | --- | --- | --- | --- | --- | --- |
| **Theme Name** | **-2** | **-1** | **0** | **+1** | **+2** | **TOTAL 1** |
| **Action Planning & Idea Generation (API)** |  |  |  |  |  |  |
| **Evaluations of Self or Therapy (EST)**  |  |  |  |  |  |  |
| **Information Discussion (IDI)** |  |  |  |  |  |  |
| **Noticing Change or Otherwise (NCO)**  |  |  |  |  |  |  |
| **Problem Analysis & Understanding (PAU)** |  |  |  |  |  |  |
| **Problem or Context Description (PCD)** |  |  |  |  |
| **Structuring & Task Focus (STF)** |  |  |  |  |  |  |
| **TOTAL 2** |  |  |  |  |  |  |
| **Integration of Themes (IOT)** |  |  |  |  |  |  |
| **Collaborative Flow (COF)** |  |  |  |  |  |  |

**Instructions:**

Multiply the proportion of the transcript coded at each level of each theme by the score for the given level (TOTAL 1). For example, if 10% of a transcript was coded as Action Planning and Idea generation (API) at the +2 level, this would contribute a score of 20 to the total for the API theme (+2 x 10). Conversely, if 10% of the same transcript was scored as API -1, this would contribute a score of -10 to the total for the API theme (-1 x 10). If these were the only levels of API coded for the transcript a total score for API on that transcript would be 10 (20-10). To calculate overall content scores, average the scores for each theme (TOTAL 2). Global themes are scored separately with a single rating on the level scored.