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Client-centered therapeutic relationship conditions and authenticity: A prospective study

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Abstract

The aim was to investigate the association between experiencing a therapeutic relationship and subsequent authenticity. Forty-six clients completed the Barrett-Lennard Relationship Inventory (B-LRI, 1968), Relational Depth Inventory (RDI, Wiggins, Elliott, & Cooper, 2012), a measure of the therapeutic alliance (ARM-5, Agnew-Davies et al, 1998) and the Authenticity Scale (AS: Wood et al, 2008) at intervals over ten therapy sessions. Higher scores on the B-LRI at sessions three, five and ten were associated with an increase in authenticity over the ten sessions. These results provide some initial evidence in support of Rogers' (1957) theory that it is the conditions of the therapeutic relationship that leads to greater authenticity.

KEYWORDS

Positive Psychology; Authenticity Scale; Relational Depth Inventory; Barrett-Lennard Relationship Inventory; Therapeutic Alliance

Introduction

Traditionally, outcome measures in the field of counselling tend to be concerned only with distress and dysfunction. But in more recent years this has been challenged with critics arguing that the use of measurement tools based on symptom reduction implicitly condones an illness ideology incompatible with the counselling profession, and that counselling should be understood not only as leading to the alleviation of distress and dysfunction but also the promotion of well-being (Joseph & Linley, 2005). Such a view dates back to the theoretical work of Carl Rogers, who developed client-centred therapy over sixty years ago (Rogers, 1951). Specifically, Rogers (1957) went on to propose that six conditions were necessary and sufficient for constructive personality change: psychological contact between the therapist and the client; the client's state of incongruence; the therapist's congruence; the therapist's unconditional positive regard; the therapist's empathic understanding; and finally, the client's reception of the therapist's empathic understanding and unconditional positive regard. A therapeutic relationship that embodies these six conditions describes client-centred therapy, and allows the client, Rogers (1959) theorized, to explore and symbolize their experiences, enabling them to move towards a more harmonious state of congruence between self and experience.

There is an abundance of research supporting Rogers' therapeutic conditions with a variety of outcomes (e.g., Murphy & Joseph, 2016; Stiles, Barkham, Mellor-Clark, & Connell, 2008). Conclusions of the most recent meta-analyses of the therapist's conditions of positive regard (Farber, Suzuki, Lynch, 2018), congruence (Kolden, Wang, Austin, Chang, & Klein, 2018) and empathy (Elliott, Bohart, Watson & Murphy, 2018) all suggest these variables are associated with client change. Empirical research has largely failed, however, to focus on the very specific aspect of Rogers' theory that the therapeutic relationship facilitates

the client's movement towards greater congruence between self and experience. Although some early research by Rogers and his colleagues attempted to do this by examining adjustment in self-concept between scores given to statements rated as 'like me' and 'unlike me' (Dymond, 1954), research over the past sixty years has instead focused on symptom based measures and not directly tested his hypothesis about movement towards increased congruence.

In large part this lack of research must be due to the absence of suitable measurement tools. However, this need no longer be the case with the development of new psychometric tests. One such test is the Authenticity Scale which is based on Rogers' (1959) concept of congruence between self and experience. The Authenticity Scale developed by Wood, Linley, Maltby, Baliousis, and Joseph (2008) consists of three components: self-awareness; the ability to take ownership of one's own decisions in life and not be governed by the expectations of others; and an openness and honesty in interpersonal situations. Prospective research by Boyraz, Waits, and Felix (2014) using the Authenticity Scale has shown the relevance of authenticity research to counselling. Using cross-lagged panel analysis has established that scores on the Authenticity Scale are predictive of greater well-being. But while the topic of authenticity is now attracting interest by psychologists, it remains to be applied to counselling, and specifically Rogers' (1957) hypothesis on the conditions of a growth promoting relationship.

The idea of the therapeutic relationship based on Rogers' (1957) theory is not to be confused, however, with the idea of the therapeutic alliance. Therapeutic alliance refers to how the client and therapist work together developing a bond of trust and confidence as they agree to tasks to achieve the client's goals (see, Hovarth et al, 2011). The therapeutic alliance is thought to affect therapeutic change with research suggesting it to be one of the best predictors of client outcome (Norcross & Lambert, 2018). The concept of the therapeutic

alliance, however, derives from psychodynamic theory and is therefore grounded in a different paradigm, one that is more goal directed and instrumental than the non-directive humanistic theory of Rogers. In order to provide evidence for Rogers' theory, it is important to show that change is a result of the therapeutic relationship, not the therapeutic alliance.

This is not to say, that the person-centred therapist does not build an alliance, but it arises indirectly, rather than instrumentally. For example, Ackerman & Hilsenroth (2003) found that a positive therapeutic alliance is facilitated through an environment in which empathy and acceptance are present. Thus, statistically, there is an expected overlap between the concepts of the therapeutic relationship and the therapeutic alliance. For example, Salvio et al (1992) found close associations between therapeutic alliance and the therapist's relationship conditions, particularly empathy; and Wiggins, Elliott, and Cooper (2012) found that working alliance was moderately associated with relational depth.

Thus it may be that the therapeutic alliance is related to authenticity, but possibly only because of its statistical association with the therapeutic relationship. In fact, the alliance may even be important in generating change if it arises as a result of the therapeutic relationship. The Barrett-Lennard Relationship Inventory (B-LRI) is a widely used tool that was developed specifically to test the therapeutic relationship as described by Rogers (1957); it provides a score for how much a client experiences themselves as being in an unconditionally accepting, positively regarding, empathic and genuine therapeutic relationship (Barrett-Lennard, 2015). In a previous study of the association between therapeutic alliance and the therapeutic conditions measured with the B-LRI it was found that the therapeutic alliance mediated the association between the B-LRI and outcome (Watson & Geller, 2005). As such, if the therapeutic alliance arises indirectly as a result of the conditions described by Rogers (1957), it may be helpful in developing authenticity, and act as a possible mediator. However, that is speculative as in Watson and Geller's study, outcome was assessed using measures to assess

depression, self-esteem, interpersonal problems, and dysfunctional attitudes. There is no direct evidence that the therapeutic alliance will be associated with authenticity. Research is therefore needed to test the separate operation of the therapeutic relationship and the therapeutic alliance with respect to authenticity.

While the Authenticity Scale has now been used in many different studies testing its personality and social correlates (Joseph, 2016), it has not yet been used in therapy outcome research, with one exception. Kim, Price, and Joseph (in press) found that in an internet sample of 55 individuals who reported that they were in psychotherapy or counselling, higher scores on the Authenticity Scale were strongly associated with higher scores on the Relational Depth Inventory (RDI). The RDI (Wiggins, Elliott, & Cooper, 2012) is a self-report measure based on the work of Mearns (1996) who first coined the term ‘relational depth’. Relational depth is defined as “a feeling of profound contact and engagement with a client” within a therapeutic setting (Mearns & Cooper, 2005, p.36). Whilst Rogers’ did not formulate the notion of relational depth, it could be argued that he described moments of relational depth with his client within accounts of their work together (Rogers, 1980) and that what is measured by the RDI is simply an emergent experience attributed to the necessary and sufficient condition described by Rogers (1957). Mearns (1997) suggests that it is through a therapist’s ability to work in a way that brings together high levels of therapeutic conditions of empathy, unconditional positive regard and congruence that relational depth is achieved.

Kim, Price, and Joseph’s (in press) study lends some support to the hypothesis that the therapeutic relationship as conceptualised by Rogers (1957) is important to the development of authenticity. It is a weakness of the study, however, that it used the RDI instead of the more established B-LRI. The use of the RDI by Kim, Price, and Joseph (in press) was

because of its relative ease of administration with an internet sample. The B-LRI is a longer and more complex tool that is best administered in a face to face setting.

The present study will test for the association between authenticity as a client outcome and these measures of the therapeutic relationship, relational depth and the therapeutic alliance. It is predicted that the B-LRI will be related to the development of authenticity as the BLRI directly tests Rogers' (1957) theory. Relational depth will be included in order to test whether it adds any additional predictive power over and above the B-LRI. The therapeutic alliance will be included in order to partial out its effects to test for the unique contribution of the therapeutic relationship, and to test a possible mediation model should our initial inspection of the data suggest that the B-LRI does not have a direct relationship with authenticity. Also, although the results from Kim, Price, and Joseph's (in press) study are supportive of Rogers' (1957) hypothesis, they are based on cross-sectional data. Thus, they don't provide evidence in support of the causal association between the therapeutic relationship and authenticity. There is now a need for further prospective research to test whether the therapeutic relationship as conceptualised by Rogers (1957) is able to predict greater authenticity over time in a clinical sample. As such, we wished to extend the findings of Kim, Price and Joseph (in press) by using the RDI and testing its longitudinal association with authenticity, but also by introducing the more established BLRI. While we think the RDI simply measures emergent properties of the therapeutic relationship as conceptualised by Rogers (1957), we are interested in the possibility that the RDI is measuring something new and able to contribute to the predication of authenticity over and above the B-LRI.

Method

Participants

A total of 46 participants took part in the research project, with 32 (70%) of the participants identifying as female and 14 (30%) identifying as male. Participants were aged between 18 and 68 (mean = 38, SD = 12.44) and 80% of participants identified as White British in ethnicity.

Instruments

Participants completed a series of self-report measures:

Authenticity Scale (AS: Wood et al, 2008). Based on Rogers' (1959) concept of congruence, the AS is a 12-item scale. Each item (e.g. "I am true to myself in most situations") is rated on a 7-point Likert scale from 1 (The Authenticity Scale does not describe me well at all) to 7 (describes me very well). In the present study we used the total of these 12 items scored in such a way that a high score demonstrates greater authenticity (i.e., negatively worded items were reverse scored). Possible participant scores could range from 12-84, with higher scores indicating lower self-alienation, greater self-direction, and the ability to be open and honest in life. The AS has been shown to demonstrate reliable psychometric properties, with Cronbach's alpha scores ranging .78 to .90. The scale also shows good test-retest correlations and benefits from high efficacy and lack of social desirability effects (Wood et al., 2008).

In order to assess the therapeutic relationship we chose two measures:

Barrett-Lennard Relationship Inventory (B-LRI: OS; Barrett-Lennard, 1962). The B-LRI is a widely used 40-item scale that was developed specifically to test the therapeutic conditions as described by Rogers (1957). It provides a score for how much a client experiences themselves as being in an unconditionally accepting, positively regarding, empathic and genuine therapeutic relationship (Barrett-Lennard, 2015). Although the B-LRI has been found to predict therapeutic outcome (Watson & Geller, 2005) it has not been previously used to

test for its association with authenticity. The version used was the other-to-self in which participants are asked to rate how well they believed each statement about their therapist (i.e. “[therapist’s name] respects me”) to be true using a 6-point Likert scale from -3 (NO, I strongly feel this is not true) to +3 (YES, I strongly feel this is true). Possible participant scores could range from -120 to +120, with subscales ranging from -40 to +40. A high score demonstrates a stronger relationship, inclusive of the conditions. The B-LRI demonstrates high internal reliability, with average scale inter-item correlations ranging from .77 to .91 (Gurmann, 1977), and Cronbach’s alpha of over .80 (Barrett-Lennard, 2015).

Relational Depth Inventory (RDI; Wiggins, Elliott, & Cooper, 2012). Clients also completed the 31-item RDI, a more recently developed self-report measure designed to measure relational depth, conceptualised as the experience that clients have when in therapeutic relationships characterised by high levels of the therapeutic conditions of empathy, unconditional positive regard and congruence (Mearns, 1996). The scale focuses on assessing qualities of intimacy, mutuality, connection and love. Items are measured on a 5-point Likert scale (e.g. “I felt my therapist was there for me”) with responses ranging from 1 (“not at all”) to 5 (“completely”). Possible scores range from 31-155. A higher score demonstrates a stronger presence of relational depth. The RDI has been shown to demonstrate reliable psychometric properties, with a Cronbach’s alpha of .79 (Wiggins et al, 2012).

Alongside the two measures of the therapeutic relationship, we chose to use a short measure of the therapeutic alliance:

Agnew Relationship Measure (ARM-5; Agnew-Davies et al, 1998). The ARM-5 was designed in order to measure the therapeutic alliance between client and therapist. It is a 5-item scale designed to measure the therapeutic alliance between client and therapist. The scale holds three subscales; Bond, Partnership and Confidence. Therapist and client versions were

constructed to contain parallel items. In the current study we were only concerned with the client's responses. Items are measured on a 7-point Likert scale (e.g. "I have confidence in my therapist and his/her techniques") with responses ranging from 1 ("strongly disagree") to 7 ("strongly agree"). Possible scores range from 5-35. A higher score demonstrates a stronger therapeutic alliance. The ARM-5 has been shown to demonstrate reliable psychometric properties, with Cronbach's alpha scores ranging from .77 to .87 (Agnew-Davies et al, 1998).

We chose the ARM-5 deliberately because it is a different conceptualization to Rogers' (1957) theory in order to be able to test for the unique contribution of the therapeutic relationship.

Procedure

The 46 participants were clients in a university research clinic which takes Master's level students on clinical training placement specialising in client-centred therapy. Each student on placement typically sees between 2 and 4 clients per week. Clients are offered therapy sessions free of charge in return for taking part in research. The 46 participants each worked with one of 18 different student therapists. Therapists were of a mix of ages and gender, but mostly identifying as females in their mid-thirties. All were in regular supervision while working and at varying levels of competence reflecting that this was a placement for them in the final year of their two year MA. Therapy sessions lasted for 50 minutes and were weekly. All therapists were on a person-centred training course and expected to practice in a person-centred way. It is recognized that the quality of the therapy on offer was likely to vary across therapists and it may be that some of our therapists were offering therapy that was not as closely adherent to the person centred approach as others. However, while that may be of concern to the clinic management, it is not a limitation of the research but actually a strength insofar as we want variability in the therapeutic relationship measures. The more variability

in scores, the more able we are able to detect statistical association. Clients were allocated to student therapists based on availability.

In the study each client had had ten sessions of therapy. For some this would be a final session but for others therapy may have continued. This study was a snap shot of those who had completed ten sessions in the clinic and using these data to test the hypothesis that ratings on relationships would correlate with authenticity. We could have had more sessions and a larger sample but less time for change to occur or more sessions but with fewer participants. Ten was a choice to have the longest timeframe but be able to maximize the size of the sample to be sufficiently powered. The study was designed as a pilot investigation to provide initial data with the aim to then reflect on our results to further develop the research protocol into a longer term study. Ethical approval was granted by the University Research Ethics Committee. Participants each attended an initial intake assessment when they were briefed of the nature of the research, what would happen with their data, and informed of their right to withdraw from the study at any point. All data collected was stored in accordance with the Data Protection Act. Informed consent was obtained during the participant's intake assessment session before therapy commenced.

Questionnaires were administered to clients by one of the eighteen therapists and completed during therapy sessions in regular intervals at the beginning of each 50-minute session. Each questionnaire was administered at three different time points. The authenticity scale was completed during session one, five, and ten. The three relational measures (B-LRI, ARM-5, and RDI) were completed during session three, five, and ten. Session three was used as the first time point for the relational measures as it is unlikely a meaningful relationship would be established during the first two sessions, and at session five when we assumed that the relationship was becoming established. Figure 1 shows the data collection timeline.

-insert Figure 1 about here-

It is recognised that the quality of the therapy on offer is likely to vary across therapists. As we are directly testing the prospective role of the therapeutic relationship as measured using tools designed to assess the client's perception of the relationship as defined by Rogers' (1957) model, the fact that there is variability in client experiences is a necessary part of the design of the study. What we are interested in is whether those clients who perceive themselves to be in a therapeutic relationship as described by Rogers (1957) change in the way that his theory predicts more than those who do not perceive themselves to be in such a relationship. We were not concerned with therapist's perceptions of the therapeutic relationship but with the client's perception, as this is the predictive condition 6 of Rogers' (1957) theory, that is, it is when the client perceives themselves to be unconditionally accepted in an empathic and genuine relationship that constructive personality change in the direction of greater authenticity ensues.

Analysis

Our analyses involved the use of Pearson correlations as generated by the use of the statistical package SPSS (Version 23). We estimated that our sample size was large enough to detect the associations of a moderate size; with an expectation that the correlation will be of at least a moderate size (i.e., $r = .30$), the sample size must be at least $n = 40$ to be able to achieve statistical significance at $p < .05$. We expected at least a moderate association because Rogers (1957) hypothesis concerning the importance of these therapeutic conditions is well supported throughout the literature with other outcomes (Murphy & Joseph, 2016).

Results

Descriptive statistics are shown in Table 1 for each of the measures at each time point. All measures were found to have acceptable internal consistency reliability in this sample. It was

found that Authenticity Scale scores were statistically significantly higher by session 10 compared to those recorded at the first session ($t = 1.93$, $df = 45$, $p < .05$) with a Cohen's $d = 0.21$. Thus, on the whole, our results are supportive of Rogers (1957) hypothesis that the therapeutic relationship is associated with increased congruence on the part of clients.

-insert Tables 1 and 2 about here-

Correlations were computed between each of the relationship variables at each time point. Results are shown in Table 2. Scores on the three relationship measures were found to be moderately associated at sessions 3, 5, and 10, suggesting that they are measuring similar, but not identical constructs.

As this was a real world study we did not select participants into the study on the basis of authenticity scores, as would be done in an experimental study. As such there were individual differences in authenticity at session 1. In experimental studies, it is intended to recruit clients who all score similarly at session 1, thus raw scores at later session are attributable to the intervention. In the case of a real world study such as this, raw authenticity scores at session 10 are not attributable solely to the intervention. Only a fraction of the variance at subsequent sessions would be expected to be attributable to the therapeutic relationship. What would be expected to be directly attributed to the therapeutic relationship, however, is the relative change in authenticity scores over the course of the ten sessions. As such, we computed a difference score for the AS between session 1 and 10, such that scores ranged from -16 to = 27 (Mean = 2.65; SD = 9.34) as our dependent variable.

Higher scores on the authenticity difference scale, indicating a change towards greater authenticity, were associated with higher scores on the B-LRI at session 3 ($r = .31$, $p < .02$), session 5 ($r = .27$, $p < .04$), and session 10 ($r = .35$, $p < .01$). A trend towards association was found for scores on the authenticity difference scale with the RDI at session 3 ($r = .19$, $p >$

.10), session 5 ($r = .24, p > .05$), and a statistically significant association at session 10 ($r = .28, p < .03$). Higher scores on the authenticity difference scale were not associated with higher scores on the ARM-5 at session 3 ($r = -.01, p > .46$), session 5 ($r = -.09, p > .28$), or session 10 ($r = -.13, p > .20$).

Thus, despite the moderate correlation between the three relationship variables, associations between the change in authenticity and the ARM-5 were not statistically significant. As such, we did not need to partial out its contributions in order to ascertain the unique effects of the therapeutic relationship as measured using the B-LRI and the RDI.

The B-LRI was more strongly associated with the AS than the more recently developed RDI, which was only found to be associated at session 10. In order to understand the unique contributions of these two relationship variables, we conducted two partial correlations: first, to test for association between the B-LRI at session 10 and the authenticity change score, with the RDI at session 10 partialled out; second, to test for association between the RDI at session 10 and the authenticity change score, with the B-LRI at session 10 partialled out. It was found that scores on the authenticity difference scale remained statistically associated with scores on the B-LRI at session 10 ($pr = .27, p < .04$) but not with the RDI at session 10 ($pr = .15, p > .16$).

Discussion

This is the first prospective study to test whether client-centred relationship conditions lead to authenticity. As well as the prospective nature of this research, the focus on authenticity is the novel feature. Although congruence has received much attention with the therapeutic literature, on the whole this has focused on the development of the therapist's congruence as one of the conditions of the therapeutic. Thus, despite the clarity of Rogers' hypothesis that the therapeutic relationship leads to greater congruence, most research into client outcomes

has used symptom-based measures based in an illness ideology. It is due to the positive psychology movement that congruence has more recently become of interest as a marker of well-being to be promoted in therapy (Joseph, 2015).

Authenticity is a novel method of outcome assessment that we introduced in the clinic. No previous research has reported on its use in a clinical context. As such, these are the first data to show the use of the Authenticity Scale as an outcome measure in clinical research. Our results show a statistically significant increase in authenticity scores for the client group. The majority of clients scored higher on authenticity by session 10 than they had at session 1, although some scored lower. It would not be expected that all clients would move towards greater authenticity unless they experienced therapy as high in the relationship conditions. But even then there will be exceptions due to life events outside therapy or other external factors.

It was found that the measures of therapeutic relationship, relational depth, and therapeutic alliance were moderately associated, but they were not synonymous in how they operated with respect to authenticity. We found that the relational conditions described by Rogers (1957) and measured by the B-LRI, and to a much lesser extent the RDI, were associated with an increase in authenticity. Our results provide some initial support specifically for Rogers' (1957) statement about the conditions that lead to constructive personality change rather than other formulations of change based on theories of the therapeutic alliance. This is what we expected as Rogers' (1957) theory predicts that the therapeutic relationship, as subsequently operationalized by Barrett-Lennard (1962), will lead to greater client authenticity.

The study was designed to allow for more sophisticated analyses than were eventually reported. First, given the results of the previous Kim, Price and Joseph (in press) study we

wanted to assess whether the RDI contributed to the development of authenticity over and above the B-LRI which would suggest that as a construct it is measuring some quality of the relationship beyond Rogers' (1957) theory of therapy. However, the RDI was not as predictive of outcome as the more traditional B-LRI. There is no previous prospective statistical research in a clinical setting testing the use of the RDI to predict authenticity and we know of no theoretical reason to expect that it would be so associated, unless it is simply a proxy measure of the therapeutic relationship as defined by Rogers (1957). Indeed, our results for the session 10 data when we partialled out the effects of the B-LRI showed that the RDI was no longer associated with increases in authenticity.

As such, it is less clear that the RDI is measuring the therapeutic relationship as described by Rogers (1957) and we would propose that future research use the B-LRI in preference to the RDI. We did not find that the ARM-5 was similarly associated with an increase in authenticity. However, we were not directly concerned with the therapeutic alliance except as a control variable. The point of including the ARM-5 was to show that scores on the B-LRI have a specific and unique association with authenticity. If it had been found to be statistically associated our intention was to partial out its effects. Nonetheless, we were surprised at the lack of association found between the ARM-5 and the AS. The ARM-5 is however a short measure and other more sophisticated measures of the therapeutic alliance exist. As such, we would propose that to take this line of enquiry further it might be recommended to use other tools to assess (Norcross & Lambert, 2018). We would not expect the therapeutic alliance to be associated with the development of congruence, but nonetheless it must be ruled out in order to show that it is the specific aspects of the relationship as conceptualised by Rogers that are important.

By this we do not mean that the therapeutic alliance is not important in other ways for other therapy traditions. We are sure that the therapeutic alliance is valuable to other

therapists who are not working in a person-centred experiential way, but it is not valuable to person-centred experiential therapists. In fact, deliberately setting out to build a therapeutic alliance would be contra-indicated if working in a person-centred experiential way as it would detract from building the therapeutic relationship by imposing instrumentality.

There are some limitations. First, although participants were encouraged to answer the questionnaires honestly and were assured that the data will be anonymised and results would not affect the availability of therapy, clients completed the measures in the presence of their therapist. It is possible, therefore, that social desirability effects may have influenced how participants completed the measures. For example, clients may have wanted to please their therapist by providing what they believed to be acceptable answers or have thought that their responses would affect the availability of future therapy to them. In future studies, we would suggest that to avoid this possibility that administration of questionnaires is carried out by researchers independently of the therapist who should remain blind to the ratings. However, this was not possible in the current investigation. In that respect it would have been useful to have obtained some qualitative data about respondents' views on taking part in the research. Additionally, questionnaires were completed during the sessions which reduced the time available for therapeutic work. However, as such practice is common in many organisations we feel that our research is informative.

Second, our final outcome assessment was at session 10 which does not provide information about the lasting effects of therapy. We would encourage research over a longer period of time to investigate the lasting effects of change. However, this was relatively small pilot study conducted in order to garner interest in developing this work on a larger scale. We now plan to use this pilot study to develop the next phase of investigation into the therapeutic relationship and its association with authenticity and positive psychological functioning with a larger sample over a longer period of therapeutic engagement.

Third, although the AS is a widely used measure in psychological research and has been shown to be related to other variables of well-being and personality in predictable ways that lend support to the validity of this assessment (Wood et al., 2008), there are various measurement issues. In particular, it seems likely that those who are very low on authenticity lack the self-awareness and knowledge to complete the scale meaningfully, possibly overestimating their level of authenticity beyond that of those who have a greater self-awareness. As such we would seek to encourage future research to explore possible behavioural indices of authenticity and the use of methods that can demonstrate reflexivity and self-awareness.

Fourth, our sample was largely composed of participants identifying as female and as white British. We think it is appropriate for future research to seek a more diverse sample in terms of ethnicity and gender in order to establish that Rogers' hypotheses are not influenced by these factors. Additionally, we do not have data on the participants in terms of their a) educational level, b) occupational experience, c) socioeconomic status, or d) the nature and severity of their problems as conceptualized by traditional symptom based measures or diagnostic categories.

Fifth, it was recognised that the quality of the therapy on offer is likely to vary across therapists. As we are directly testing the prospective role of the therapeutic relationship as measured using tools designed to assess clients' perception of the relationship as defined by Rogers' (1957) model, the fact that there is variability in client experiences is a necessary part of the design of the study. What we are interested in is whether those clients who perceive themselves to be in a therapeutic relationship, as described by Rogers (1957), change in the way that his theory predicts more than those who do not perceive themselves to be in such a relationship. We were not concerned with therapist's perceptions of the therapeutic relationship but with the clients perceptions, as this is the predictive condition 6 of Rogers'

(1957) theory; that is, it is when the client perceives themselves to be unconditionally accepted in an empathic and genuine relationship that constructive personality change in the direction of greater authenticity ensues.

Sixth, we included a measure of therapeutic alliance to be able to partial it out to show that it is the specific aspects of the relationship as conceptualised by Rogers that are important. However, our results may be a function of the particular measure of alliance we chose, largely for its brevity, and as such we would encourage researchers to develop this line of enquiry further by using other measures. Seven, as a research clinic, clients are asked to engage in the research instead of payment for therapy. While there are advantages to this in terms of offering a free service to the local community it may be that influences how a participants engage with the research. This is itself an interesting question worthy of future exploration using more qualitative methods.

In conclusion, this was an initial pilot study conducted one year on from the establishment of a new research clinic. As such, our sample was relatively small. However, the results show that relational factors present in therapy are predictive of increased authenticity. As such, although a relatively small sample it was sufficiently powered to detect the hypothesised association. Forty-six clients completed the Barrett-Lennard Relationship Inventory, Relational Depth Inventory, a measure of the therapeutic alliance and the Authenticity Scale at intervals over ten therapy sessions. This was the first study to present prospective data from a clinic to use authenticity as an outcome variable in a therapeutic context and to test for its association with these therapeutic relationship variables. Results provide some initial evidence that the conditions of the therapeutic relationship lead to greater authenticity. This finding provides support for the client-centred approach to helping people move toward greater positive psychological functioning and will be of interest to researchers, therapists, and coaches interested in the promotion of human flourishing.

Disclosure statement

No potential conflict of interest was reported by the authors

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Figure 1: Data Collection Timeline

Table 1: Mean Scores, Standard Deviations, and Cronbach's alpha values for the Authenticity Scale and the relationship measures at each time point.

	Session 1			Session 3			Session 5			Session 10		
	Mean	SD	α	Mean	SD	α	Mean	SD	α	Mean	SD	α
AS	51.37	12.81	.82				51.59	13.14	.87	54.02	11.63	.81
ARM-5				25.54	4.13	.88	26.63	2.42	.88	26.67	2.79	.92
BL-RI				59.59	31.22	.93	63.87	26.40	.91	67.22	30.58	.88
RDI				93.90	18.71	.92	96.72	17.33	.90	95.08	18.45	.93

NB. AS = Authenticity Scale; ARM-5 = Agnew-Relational Measure; RDI = Relational Depth Inventory; BL-RI = Barrett-Lennard Relationship Inventory

Table 2. Correlations between the ARM-5, RDI and the B-L RI at each time point (session number in brackets)

	ARM-5 (3)	BL-RI (3)	RDI (3)	ARM-5 (5)	BL-RI (5)	RDI (5)	ARM-5 (10)	BL-RI (10)
ARM-5 (3)								
BL-RI (3)	.47**							
RDI (3)	.69**	.48**						
ARM-5 (5)	.80**	.44**	.55**					
BL-RI (5)	.55**	.82**	.47**	.43**				
RDI (5)	.66**	.48**	.90**	.58**	.48**			
ARM-5 (10)	.71**	.34**	.50**	.91**	.31*	.48**		
BL-RI (10)	.54**	.78**	.41**	.51**	.79**	.53**	.40**	
RDI (10)	.45**	.42**	.75*	.48**	.37**	.79**	.41**	.43**

** Correlation is significant at the 0.01 level (1-tailed). * Correlation is significant at the 0.05 level (1-tailed).

ARM-5 = Agnew Relational Measure; BL-RI = Barrett-Lennard Relationship Inventory; RDI = Relational Depth Inventory