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First insights in adherence of Yucel therapists

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Abstract

Research concerning therapist adherence plays an essential role in understanding the usefulness of the protocol of an intervention. Awareness of the level of adherence to a protocol can be used in training and supervision of therapists and might impact the treatment outcome. This study is the first to examine therapist adherence to the Yucel (Home) method. In this study it was assessed, using the six core elements of Yucel adherence, how adherent therapists were, and if the level of adherence changed over time in total and per element. Questionnaires were completed by therapists (N=18) and clients (N=22). Data of 67 questionnaires were examined by means of *t*-tests, ANOVA analyses and regression analyses. Therapists had an average adherence score of 69%. This can be considered as adherent. Contrary to expectations based on other research, adherence did not change over time. But a significant difference was found between adherence concerning some of the core elements of the method, and a significant change in adherence over time was found for one element. No difference was found between online sessions (Yucel Home method) and regular face-to-face sessions. In this study it was shown that the therapists involved were adherent to the Yucel (Home) method.

Keywords: adherence, treatment integrity, Yucel method, online therapy

Abstract

Onderzoek naar therapeut adherence (therapietrouw) is een essentieel onderdeel in het verkrijgen van inzicht in de bruikbaarheid van een interventie. Kennis over het niveau van adherence van therapeuten kan gebruikt worden om de therapeuten beter te begeleiden in onderdelen van de methode waarin zij nog niet voldoende adherent zijn. In deze studie werd nagegaan hoe adherent therapeuten waren aan de Yucelmethode (Thuis), en of het niveau van adherence veranderde met de tijd. Er werd nagegaan of er verschil was in de zes kernelementen van adherence, en of het niveau van adherence van deze kernelementen veranderde met de tijd. Vragenlijsten werden ingevuld door therapeuten (N=18) en cliënten (N=22). Data van 67 vragenlijsten werd onderzocht middels *t*-tests, ANOVA-analyses en regressieanalyses. Therapeuten hadden een gemiddelde adherence score van 69%. Dit betekent dat de therapeuten adherent waren. Het niveau van adherence veranderde niet in de loop der tijd. Wel werd er een significant verschil gevonden in adherence in betrekking tot een aantal kernelementen. Er werd een significante verandering van adherence in de tijd gevonden voor één element. Er werd geen verschil gevonden in adherence tussen Yucelmethode Thuis sessies en reguliere Yucel sessies. In deze studie werd aangetoond dat de betrokken therapeuten adherent waren aan de Yucelmethode (Thuis).

Sleutelwoorden: adherence, therapietrouw, behandelintegriteit, Yucelmethode, online therapie

Introduction

The Yucel method, with its captivating slogan ´building for recovery´, is growing in popularity among Dutch care providers. Developed by Mehmet Yucel, the Yucel method invites clients to express their life story by means of building with colorful blocks. The block ensemble becomes a visual representation of the client's life; their struggles and strengths are displayed in a tangible way. With different types of blocks, clients can build for instance a setup that represents their life at this moment, or a ´dream setup´ representing a desired future. By building a future- or dream setup clients can envision what their life can become; this provides them with a hopeful outlook. The method allows clients to see and talk about their problems in an externalizing way, it allows them to talk about 'the blocks' instead of the problem itself. By putting their perceived strength and problems in the form of blocks on the table, they create distance and thus identify themselves less as the person with a problem, and it helps them to see the problem as something they can change. By rearranging the blocks, clients can rearrange their thoughts. Because of its tactile and visual nature, the Yucel method can support people who find it difficult to express themselves through language. The philosophy behind the Yucel method is one of empowerment, agency and exploring one's own strengths. There is a strong focus on recovery and resilience. It requires a special attitude of the therapist; they need to take a step back and let the client lead the way. The client is the one who directs the session; they choose the blocks, build their life's setup and propose solutions to their problems. The Yucel method is not only used in traditional therapy settings, but also in families, teams and between colleagues. Furthermore, the Yucel method is also used with clients with a mild intellectual disability (MID) or borderline intelligence (BI) (Yücel, 2016). People with MID or BI have problems with intellectual and adaptive functioning. Problems occur in the social, practical and conceptual area. People with MID are relatively weak in problem-solving, learning and show difficulties in communication (Woittiez et al., 2018). The Yucel manual is written according to 'Taal voor allemaal' (language for all); which is a guideline for presenting information in such a way that people with low literacy skills (and that includes many people with MID or BI) can understand the message. This makes the Yucel method more inclusive.

The development of the Yucel method started in the early childhood of the mother of Mehmet Yucel. As a young child she was often alone and she needed a way to express her inner world, process her emotions and reflect. She discovered that processing her life could be done by means of different coloured beans, with each colour its own meaning. Mehmet

Yucel learned this method and adapted it into a therapeutic tool, transferring the coloured beans into colourful blocks. In the development of the Yucel method, Mehmet Yucel was, as a therapist, inspired by different schools of thought. One of these inspirations is Family Group Conference, a method that focusses on strengths and resources of families that can help solve problems of their children, with the help of their network (Dijkstra et al., 2017). Another inspiration is the 'balance model', a way to analyses someone's 'carrying capacity' and one's 'load'. In other words, finding out the balance between how much resources one has and how many adversities (Bakker et al., 1998). Other inspirations in the development of the Yucel Method are system therapy, creative therapy and narrative therapy (Yucel, 2016). The Yucel method bears aspects of client-centered therapy (CCT) and solution-focused brief therapy in its approach. In client-centered therapy, developed by Carl Rogers, the emphasis is on self-direction of the client. The therapist is non-directive (Hill & Nakayama, 2000). Like in CCT, the Yucel method also addresses participants as clients instead of patients. Solution-focused brief therapy is a therapeutic approach in which clients are seen as the expert of their situation. The therapist is "leading from one step behind" (Roeden et al., 2009, p. 253). Research shows that solution focused brief therapy has strong empirical evidence. It generates positive results for the clients involved and evidence suggests that clients prefer the practical and strength-based method (Gingerich & Peterson, 2013).

In its application, with its tactile nature, the Yucel method is quite a unique method. One method which has some resemblance with the Yucel method is that of 'Family Constellations', used in systemic therapy. In the Yucel method, the family system plays an important role in building the setup. Clients can be asked to think about which role family members play in their lives, are they a burden or a strength in their setup? Similarly, in a Family Constellation session, a client gains more insight into the underlying family dynamics by placing their family members in different spots in the room or on the board. The family members are arranged according to how the client experiences the relationships between family members. Some are closer to each other, some are further away. The method works with both real people, who function as stand-in family members, as with a Family Board which works with figures and symbols (Cohen, 2006).

A recent development within the Yucel method is the home version of Yucel method (Yucel Home method). The approach is the same, but the therapeutic sessions are held via a videocall. Clients receive the box with the blocks at home, and via a videocall, the therapist joins them online. The clients receive an identical but smaller box of Yucel blocks at home. These blocks are for the clients to keep. Besides the session being held online, there are no

other differences between the original face-to-face Yucel method session and the online Yucel Home methods session.

With the uprise of Covid-19 from December 2019 onwards, online psychotherapy is more relevant than ever. Most therapists still shy away from online therapy, as they are worried that they are not able to build an effective therapeutic alliance (Roesler, 2017). However there is some research in which is shown that online therapy sessions can be as effective as face-to-face therapy (Simpson, 2009), and that the online experienced therapeutic alliance between client and therapist can be similar to the therapeutic alliance established in a face-to-face session. Some clients even prefer therapy via a videocall over face-to-face contact (Simpson & Reid, 2014). Békés and Aafjes-van Doorn (2020, p. 245) point out that more experience with online therapy leads to a more positive attitude among therapists towards online therapy. The Yucel Home method seems a promising alternative to face-to-face contact.

In order to work with both the face-to-face and online version of the Yucel method, therapists need to be trained in how to comply with the protocol. Following a protocol, and implement the protocol as intended has been described as *treatment integrity* (Waltz et al., 1993), sometimes called *treatment adherence* or *treatment fidelity*. As Perepletchikova (2011) mentions: "Treatment integrity is essential for empirical testing of intervention efficacy, as it allows for unambiguous interpretations of the obtained results" (p. 148). Without knowing the level of treatment integrity, it is difficult to interpret the treatment effects. It should be noted that treatment integrity alone is just one variable that affect treatment outcomes.

Treatment integrity consists of adherence and competence. Competence refers to how proficient the therapist is in implementing the protocol. Competence in relation to treatment integrity goes beyond being a good therapist, it means being competent in skillfully delivering the treatment, with the particular attitude that comes along with that treatment. In one treatment, proximity of the therapist might be an important aspect of the treatment, whereas in another treatment, distance might be more suitable. Adherence refers to following the protocol step by step, implementing it as it was intended (Waltz et al., 1993, pp. 620-621). In the academic field there is no consensus on the conceptualization of treatment integrity. It varies from equating treatment integrity with adherence to more complex definitions including competence, responsiveness, therapist effect (Katz, et al., 2018) and treatment differentiation. However, the more straightforward conceptualization of treatment integrity, i.e. adherence, continues to be used in current research since it has the advantage of being

simple and inexpensive (Schulte et al., 2009).

Adherence is often measured by professionals, trained in rating the treatment sessions. These professionals are trained in evaluating videotapes or recordings of the sessions. This is considered an intensive and time-consuming task (Webb et al., 2010, p. 201). In a study of Herschell et al. (2020), the therapist, the client and an independent expert rater were used in measuring adherence. Results showed that the experts rated the therapist adherence lower than both the therapist and the client rated adherence. One explanation is that expert raters are better trained in observing adherence. Furthermore, clients might overestimate the adherence of the therapist. Earlier research on therapist self-report of adherence shows mixed results, some research found that therapist tend to overestimate themselves, others found that therapist self-report of adherence is in accordance with expert ratings (Chapman et al., 2013, as cited in Herschell et al., 2020, pp. 93). Apart from evaluating recordings, a checklist to determine if the instructions of a protocol are followed, is also often used. This method is considered one of the most straightforward methods to determine adherence (Waltz et al., 1993). Lack of time and funding are the main reason why in most studies on treatment outcomes, treatment integrity is often not adequately reported (Cox et al., 2019).

According to Waltz et al. (1993, pp. 624-629), most of the existing treatment integrity measures are flawed. To overcome these flaws, they have outlined five recommendations. The first recommendation is regarding how competence is defined. Competence isn't a fixed concept but rather relative to the treatment itself. Therefore, criteria should be derived from the treatment manual. The second recommendation refers to the questions that make up the competence and adherence questionnaire or checklist. These questions need to be carefully designed to measure the right construct. The third recommendation refers to treatment differentiation. The measure used must be designed to answer at least four questions about treatment differentiation. These four questions should address questions regarding; 1) the specific behavior of the therapist which are fundamental to the treatment, 2) behavior that is necessary but not exclusive for that treatment, 3) behavior that is congruent with the treatment but not crucial and 4) behavior that is prohibited. These questions help to differentiate the treatment from other treatments. The fourth recommendation refers to how to determine the level of competence of the therapist. Important considerations are; the stage of therapy, how challenging the client is, and the type of problems the client displays. The fifth recommendation is regarding the competence of the raters, they should be trained in the treatment themselves in order to be able to rate the treatment integrity competently. These five recommendations function as guidelines for developing a treatment integrity

measurement scale. Although treatment integrity is a complex variable to measure, these guidelines offer researchers a fair chance at developing an adequate instrument. Not all scholars recommend an extensive instrument to measure treatment integrity. Schoenwald et al. (2000, pp. 87-88) suggest that instruments that are brief and relatively simple to use are more favorable as opposed to more complex and time-consuming instruments, because in the mental health care field time and funding are limited.

Understanding the level of adherence is crucial. When therapists adhere to the protocol there is a certainty that you are measuring the effects of the protocol, not a mix of different therapeutic techniques. Sometimes therapists favor their own or their client's preferences in the therapy session, modifying the protocol to fit their specific needs and ideas (Waller, 2009). Therefore, adherence checks are important, as Gresham et al. (2000) state: "…researchers must be able to state that their interventions were implemented as planned or intended and were not modified or otherwise changed substantially by those responsible for implementing the treatment" (p. 198). In a method like Yucel a therapist can easily slip into steering away from the protocol, as this method is probably based on a whole different attitude of what the therapist is used to expose; where the therapist for instance normally directs the therapy session and suggests solutions to the client's problems, he or she now needs to virtually sits back and let the client lead the session. In other words, in order to adhere to the protocol, some therapists need to change their therapeutic style, and this can be quite challenging for them.

According to a study of Lange et al. (2017) on adherence in Multi System Therapy, therapist adherence is not a fixed concept but rather varies over time in the course of the treatment sessions. They found that therapist adherence increases with the experience of the therapist. In a more recent study of Lange et al. (2019) it is shown that adherence increases more strongly in the initial months of the treatment and stabilizes halfway through the treatment. Furthermore, it shows that adherence can even vary within a single treatment session. Having insight into the specific moments where the therapists might need some extra support in order to achieve a higher level of adherence can be very helpful in making sure the therapist receives adequate and efficient support.

Studies on the relationship between treatment adherence and treatment outcome in for instance individual drug counseling showed mixed results. According to a study of Barber et al. (2006) high and low levels of adherence were correlated with negative outcomes, whereas average levels of adherence corelated with positive outcomes. One of the reasons why higher adherence is not always linked to the desired outcome is that following the treatment protocol

strictly can be too rigorous and leaves no room to respond to the client's needs. Whereas low levels of adherence can indicate that the treatment is too difficult to bring into practice for the therapist (Barber et al., 2006). This indicates that adherence is not straightforwardly linked to a better outcome. Besides treatment outcome, understanding the level of adherence can give valuable information about the protocol. If adherence is consistently low among therapists, it could be that the instructions in the protocol are too difficult to adhere to. It could mean that the instructions are not adequately described or that the descriptions in the protocol are possibly too vague and open for interpretation. It could also be that the treatment doesn't fit the type of problems it is used for. The data yielded from measuring the level of adherence give direction for further research on the treatment protocol.

In some treatments, monitoring adherence is a part of the treatment protocol. Multisystemic therapy (MST) is one example where adherence monitoring became part of the protocol. In the publication of Schoenwald et al. (2000) the difficulties in measuring adherence in MST are outlined. MST is a community-based intervention for adolescents with delinquent behavior and their families. The focus of MST is on interactions between the adolescent and the system around the adolescent. Because the system (family, peers, school and other organizations) surrounding an adolescent varies and the specific needs of the adolescent and the partners in the system vary, the procedures within the MST also vary, catering to the needs of the adolescent. They are based on a different, tailor-made set of procedures in each MST trajectory. It is therefore in advance difficult to specify all procedures and foreseen outcomes of MST and to measure the adherence of the treatment. Although there are many different possible combinations of intervention techniques within MST, the core of MST consists of nine treatment principles. Based on these nine treatment principles a 26-item MST Adherence Scale (Henggeler & Borduin, 1992 as cited in Schoenwald et al., 2000, pp. 88) was developed. The MST adherence scale does not measure specific intervention techniques but assesses if the intervention is true to the nine MST treatment principles by the use of multiple informants (youths, caregivers and therapists) and is relatively user-friendly, that is it doesn't bring a strain onto the informants. In two MST studies, 'the Diffusion study' and the 'Substance Abuse study' there is an observed relationship between adherence and outcome. Adherence was measured by caregivers, youths and therapists in randomly selected treatment sessions. To understand which aspects of adherence influenced the treatment outcome in both studies, multiple regression analyses were conducted. Because the results showed that the adherence scores were low a procedure was developed to strengthen the adherence in a new trail study; the 'Alternative to

Hospitalization' study. During this trail each week an independent MST therapist listened to recordings of the therapy session and rated the adherence through a questionnaire addressing the nine principles of MST. The information derived of these ratings where used during supervision meetings where the therapists conducting the therapy would receive detailed feedback about which of the nine MST principles needed more attention. Furthermore caregivers, youths and therapist rated the adherence of the therapy by using the MST Adherence Scale. In the so-called 'Alternative to Hospitalization study' significantly higher adherence scores then in the 'Diffusion study' and the 'Substance Abuse study' were revealed. This indicates that informing a therapist immediately about the level of adherence and train him or her in aspects where he/she fails to adhere to the protocol can help enhance adherence (Schoenwald et al., 2000).

Building upon the adherence research, the Yucel method has been implemented in a Dutch mental healthcare organization called Koraal, with adherence monitoring integrated in the protocol. First, after each session the therapist receives an email to fill out a questionnaire about adherence. Beside that these questionnaires yield valuable information, the therapist is also asked to reflect on their level of adherence. This reflection functions as a reminder for the therapist about the rationale of the Yucel method, which could positively influence the level of adherence. Second, clients are interviewed over the phone by an independent rater to evaluate the therapist adherence every 1,3,5th etc. session. The adherence questionnaire was developed by Mehmet Yucel and a team of therapists who were familiar with the Yucel method for considerable time. Together they translated the rationale of the Yucel method and identified the six core elements / principles of the method which were subsequently transferred into a questionnaire. A first example of an element is using 'Green questions'. According to the method the therapist is supposed to ask questions that help to map out positive traits, resources and skills of the client which are called 'Green questions'. In order to adhere to the Yucel protocol, asking 'Green questions' is required. A second core element of the Yucel method is; 'Explanation of the blocks', refers to explaining the meaning of the shape and color of the blocks. A third element is 'Bars', which refers to explanation of the long wooden bar, which represents the core of the setup. A fourth core element is 'Non-directiveness' referring to one of the core concepts of the Yucel method, that is, letting the client direct the session and the therapist follows as much as possible. A fifth core element is 'Taking and discussing pictures' because this enables the client to reflect and see their progress. By looking at a picture of the previous setup, the client can compare with their current situation and see how much they have grown. A sixth core element is 'Focusing on

strengths'. In the Yucel method, the therapist needs to ask questions that empower the client and by doing this making the client aware of his or her own strengths and family/network. Although all six elements are important to the Yucel method, some are imperative to the method and weight more than others. 'Explanation of the blocks' and 'Focusing on strengths' are two such of those core elements who are because of their importance weighted double in the adherence questionnaire.

As outlined above, competence is, together with adherence, an important part of treatment integrity. In the Yucel method, competence is safeguarded by means of a training, follow-up sessions and supervision meetings. Questions about competence are not part of the adherence questionnaire. Competence is presupposed because of the extensive attention paid to training and supervision of the therapists.

Although the Yucel method has been used for more than two decades, little research has been done neither on the Yucel method, nor on Yucel Home variant. This study is one of the first to evaluate elements of the Yucel method and the Yucel method Home. Since there is only anecdotal evidence of adherence, this study is a first step in understanding the level of adherence. The outcome of this study can provide directions for future research on the Yucel method. Furthermore, with the current pandemic (Covid-19) understanding important issues concerning online use of the Yucel method is now more relevant than ever. This study is a first step in understanding if and how therapists adhere to the Yucel protocol, both the original as the Home variant.

The central research question of this study is: *Do the therapists adhere to the Yucel (Home) method protocol?* This central research question will be addressed using the following questions: (1) How adherent are therapists? (2) Is there difference in adherence between the six core elements of the method? (3) Is there a change in the average adherence over time? (4) Is there a difference in adherence between the six core elements of the method over time? Based on theory presented it was expected that the level of adherence increases over time.

Method

Design & procedure

In this study the level of adherence to both the Yucel method and the Yucel Home method was assessed. Data were collected at Koraal, an institution for mental healthcare in which people of all ages with serious (mental) disabilities and complex behavioral and/or

psychiatric problems are treated. Koraal also has several schools for pupils with behavior or learning difficulties. To research adherence, two adherence questionnaires were used. As mentioned earlier, these adherence questionnaires were developed by a team of Yucel method experts. One questionnaire was answered by therapists and the other questionnaire was answered by the clients about aspects of adherence of the therapist. The therapist questionnaire consisted of 22 questions. After each session an email was sent to the therapist asking him or her to answer the questionnaire online, rating their level of adherence. Clients received a phone call by a trained professional shortly after the 1st, 3rd, 5th, etc. session (if applicable), and after the last session. This call took about 10 minutes at a time. The client questionnaire consisted of 15 questions. Some of these questions were only asked after the first session. The collected data was both from the regular Yucel version, i.e. face-to-face meetings, as from the Yucel Home version, i.e. online. Therapists had the freedom to choose the face-to-face version or the online version or a mix of both versions. This is the first time that these questionnaires were used, therefore, no data is available about the reliability and validity of both questionnaires.

Participants

The participants in this study were therapists and clients of Koraal. A total of 40 participants participated in this study: 22 clients and 18 therapists. Clients were adult clients of Koraal (n=4), parents/caregivers of youth who received treatment by Koraal and were involved in therapy sessions (n=9) or youth (younger than 18 years old) themselves (n=6). The sample also included a few employees of Koraal (n=3) because the Yucel method can also be used in coaching sessions. There were no specific including criteria for professionals to be trained in the method. The therapists were a mixed group of trained professionals with different professions. Amongst them were behavioral scientists, psychologists and in-home counselors. Besides that they participated in Yucel sessions, there were no special including or excluding criteria for clients. Information about what type of client (parent or youth), what other treatments clients received and which phase of the general treatment (the start or end of the treatment, in-home, outpatient, hospitalized etc.) the clients were in was collected. Furthermore, only the initials from the clients and the first name of the therapist were collected. Therapist and clients were paired by means of a unique code for example ‘A2_sessie 1’. No other data were collected so the anonymity of the clients was guaranteed. Recruiting of clients was done by the therapist who estimated, not based on formal criteria, which clients were suitable for applying the Yucel method/ the Yucel Home method. The

clients and therapists were informed in advance about the study and gave verbal consent to participate in the research.

Measures/materials

Adherence was operationalized by the following six core elements: ‘Green questions’, ‘Explanation of the blocks’, ‘Bars’, ‘Non-directiveness’, ‘Taking and discussing pictures’ and ‘Focusing on strengths’. See appendix 1 and 2 for both questionnaires in Dutch.

‘Green questions’ were assessed by 2 items in the client questionnaire and by 3 items in the therapist questionnaire. An example of a question in the client questionnaire was: ‘Who chose how the blocks with burdens could be made smaller?’ and in the therapist questionnaire: ‘Did you ask the client how they solved their problem in the past?’.

‘Explanation of the blocks’ was assessed by 6 items in the client questionnaire and by 7 items in the therapist questionnaire. Questions in the client questionnaire were: ‘Did the therapist explain the meaning of the T-shaped blocks?’ In the therapist questionnaire this was assessed by questions such as: ‘Did you explain the meaning of the T-shaped blocks?’ Four of these questions were only asked after the first session in both the client and the therapist questionnaire. The remaining questions were asked during every questionnaire.

‘Bars’ was assessed by 1 item in the client questionnaire and 3 items in the therapist questionnaire. The question in the client questionnaire was: ‘Who picked the bar?’ In the therapist questionnaire this was assessed by questions such as: ‘Did the client pick the bar?’

‘Non-directiveness’ was measured by 2 items in the client questionnaire and by 3 items in the therapist questionnaire. An example question in the client questionnaire was: ‘Who choose the words written on the blocks?’ In the therapist questionnaire this was assessed by a question such as: ‘How often did you give advice to the client how he/she could solve their problems?’

‘Taking and discussing pictures’ was assessed by 3 items in the client questionnaire and by 3 items in the therapist questionnaire. An example of a question in the client questionnaire was: ‘Did the therapist take a picture of the setup?’ and in the therapist questionnaire: ‘Did you take a picture of the setup?’.

‘Focusing on strengths’ was assessed by 1 item in the client questionnaire and by 3 items in the therapist questionnaire. The question in the client questionnaire was: ‘Did the therapist ask questions about things that help you’? In the therapist questionnaire this was assessed by a question such as: ‘Did you ask questions about what makes the client happy/relaxed?’.

Data analysis

The research questions were answered by analysis of the questionnaires using SPSS 27. The assessment of the questions was done based on the therapist answers only, because the therapist questionnaire contained more questions than the client questionnaire and the therapists answered the questionnaire after every session whilst the clients answered the questionnaire after every other session. The data derived from the client interviews was used to check the difference between the therapist answers and the client answers, to see if there were any differences between the client adherence scores and the therapists scores. The information derived from this check was only used as additional informative data to gain more insight into possible different perspectives on therapist adherence.

To answer the first question; 'How adherent are therapists' only data from the first therapy session of the client-therapist dyad was used because the majority of the data was from the first session or one instance of Yucel method use. Percentage values were assigned to the answer options, for example, often=100% sometimes=50%, never=0%. The average scores of the questions was used as the adherence per element. All elements had an equal weight except for 'Explanation of the blocks' and 'Focusing on strengths', which were weighted double because of their relative importance in the method. Then, the average adherence score of the six different elements was used as the total adherence score per session. Similar to MST adherence research (Lange et al., 2016) a score of 61% or more was considered adherent. As mentioned above, differences in answers between clients and therapists were checked by comparing the adherences scores in total by means of a paired *t*-test. For clients the procedure for calculating the adherence scores was the same as the procedure of calculating the adherence score for therapists. The only exception was the possibility for the client to answer, 'I don't know', which was treated as missing data.

To answer the second question 'Is there difference in adherence between the six core elements of the method?' an ANOVA analysis was executed. This test was chosen to show whether there was a significant difference between the elements. The total score per element was based on the therapists' answers and differences in answers between clients and therapists were checked.

To explore the third question, ´Is there a change in the average adherence over time?´ a regression analysis was conducted. The analysis was done based on the therapists' total adherence score but using the session number as independent variable in a regression analysis. In this analysis questions were excluded that were only relevant for the first session (i.e. explanation of the blocks questions 1 to 4). Only the datapoints for dyads with multiple

sessions were used for this analysis (n=8). Differences in answers between clients and therapists were checked.

Similarly, a regression analysis was done for each of the adherence elements to answer the final question 'Is there a difference in adherence between the six core elements of the method over time?'. This analysis was also done based on the therapists' answers and differences in answers between clients and therapists were checked. If the adherence changed over time this would show a significant trendline in the regression.

Results

Preliminary analysis

A preliminary analysis was undertaken. In total, the data of 67 sessions were analyzed. There were 22 clients and 18 therapists who completed the questionnaires. In total there were 22 client-therapist dyads. From these dyads, 8 dyads were based on multiple sessions. One client stopped after the first session, before the client was interviewed. For this reason, this therapist-client dyad was removed from the sample. From the data collected, 19 datapoints (1,6%) were considered missing data. In the assessment of the data there was no distinction made between data from the Yucel method and the Home variant, since adherence should be the same. The differences in results concerning adherence between the Yucel method and the Home variant were tested for a significant difference with an independent samples *t*-test. In the data it can be shown that the clients rated adherence consistently higher than the therapists as that they did on average for every question answered. Therefore, beside for the first question, the differences between client scores and therapists scores will not be further explored for each individual research question.

Main analysis

The first research question; 'How adherent are therapists was answered by performing a descriptive variable. A filter was used to include only the first session of a therapist-client dyad. Table 1 shows the average therapist and client adherence scores and standard deviations per element. On average therapists had an adherence score of 69%. This score (M=69, SD=11), is significantly larger than the threshold score of 61% ($t(20) = 3.199$ $p= .0025$). The therapists rated their level of adherence lower than the clients. On average clients reported an average adherence score of 84% (SD=17). A paired *t*-test showed that the difference between client scores (M=84, SD=17) and therapist scores (M=69, SD=11) was significant ($t(20) = -4.259$ $p= <0.001$). A difference is considered significant when $p < 0.05$.

To answer the second research question; ‘Is there difference in adherence between elements of the method’ an ANOVA test was executed based on the therapists´ answers. By using an ANOVA test, it was shown that there was a significant difference in adherence between the six core elements of the method ($F(5,221) = 17.144$, $p = < 0.001$). In order to get a better understanding of the average adherence it is necessary to look at the average adherence of each element separately. Graph 1 shows the difference of adherence between elements, according to the therapist. Table 1 shows the different adherence score per element. The average adherence scores of the elements ‘Green Questions’ (44%) and ‘Taking and discussing pictures’ (54%) are considered not adherent. The elements ‘Explanation of the blocks’ (76%), ‘Non-directiveness’ (72%) and ‘Focusing on strengths’ (68%) are around average adherence. The average adherence score of the element ‘Bars’ (94%) is considerably high.

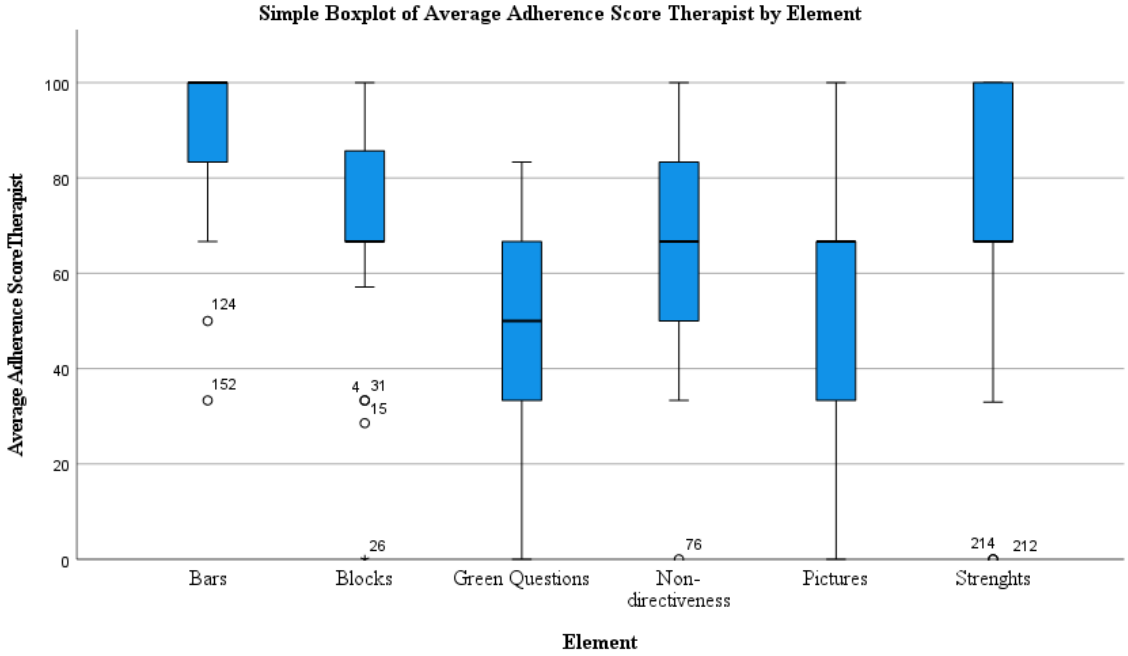
Table 1

Average adherence scores according to therapists and clients

Element	Therapist	Client
Green questions	44 (±24)	84 (±23)
Explanation of the blocks	76 (±15)	83 (±24)
Bars	94 (±10)	98 (±11)
Non-directiveness	72 (±24)	73 (±24)
Taking and discussing pictures	54 (±20)	73 (±29)
Focusing on Strengths	68 (±25)	89 (±31)
Total	69 (±11)	84 (±17)

Graph 1

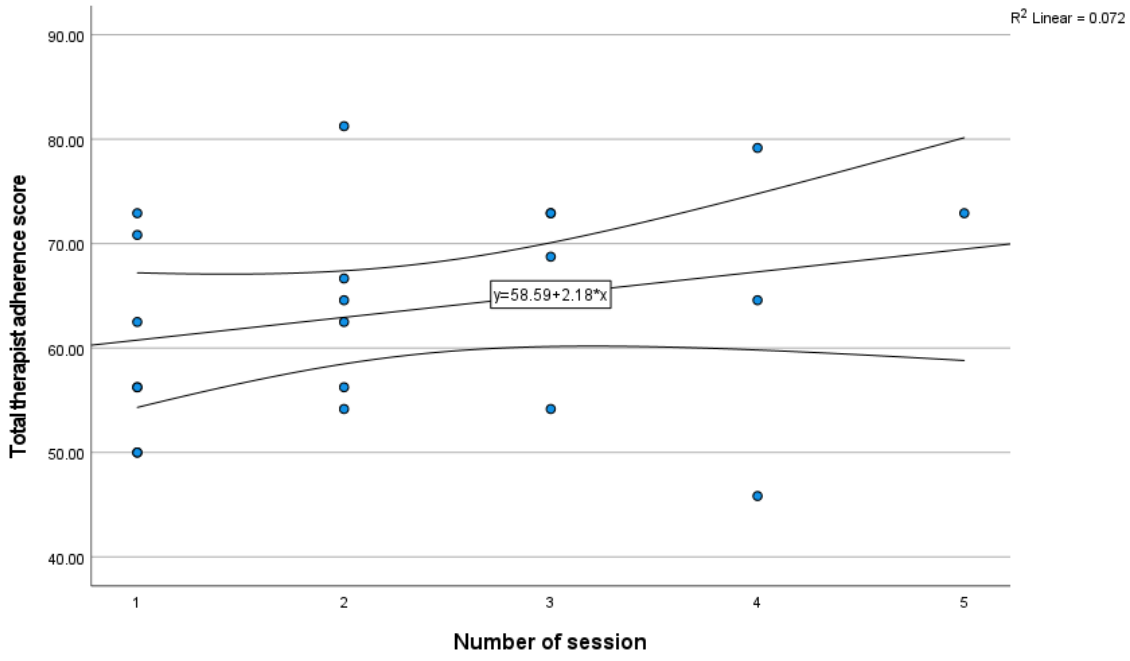
Average adherence score per element according to therapists



The third research question; 'Is there a change in the average adherence over time?' was answered by means of a regression analysis. For this regression analyses only the data from the therapist was used. Graph 2 shows that there was no significant effect of the number of sessions on the average adherence score (B =2.245, t (20) = 1.305, p = .206). Very little variance was explained, adjusted R square = .031 F (1,20) = 1.704, p =.206).

Graph 2

Average adherence progress over time according to therapists



To answer the fourth research question; 'Is there a difference in adherence between elements of the method over time?' a regression analysis was carried out. For this analysis the dyads that were only based on one session were excluded. Thus, the data from 22 questionnaires were analyzed. The results are shown in Table 2 and in graph 3. In table 2 the average increase or decrease in adherence per session per element is shown. It must be noted that only for 'Green questions' there was found a significance difference. A difference is considered significant when $p < 0.05$. This means that the average adherence for the element 'Green questions' increased over time. The average adherence for the other elements remained stable. In graph 3 this progress over time is shown.

Table 2

Average adherence progress over time per core element according to therapists

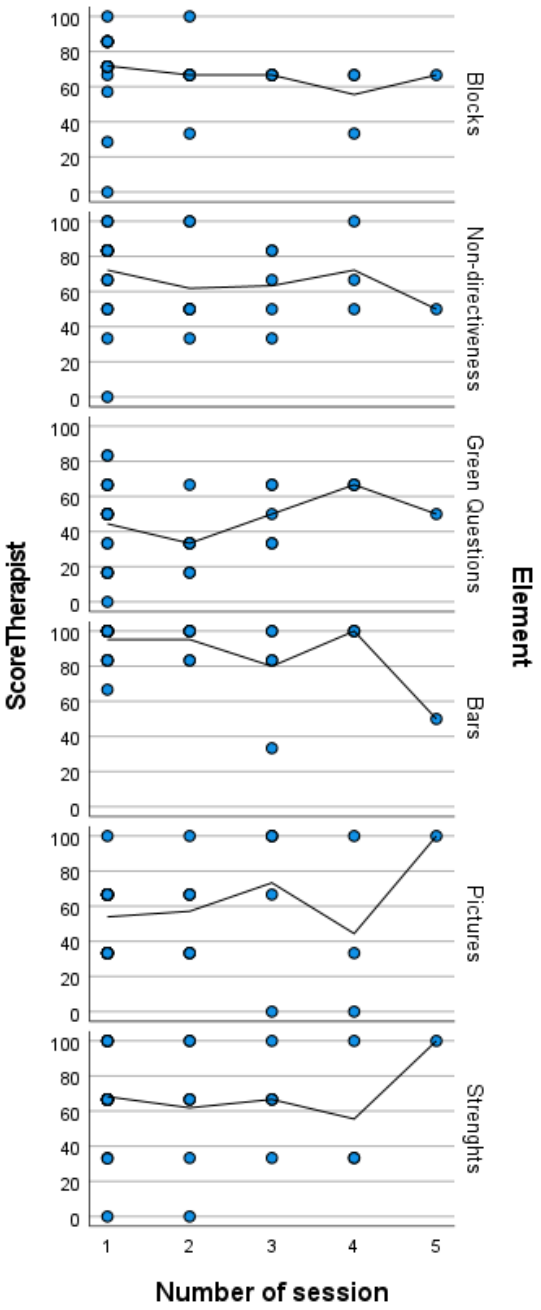
Element	Coefficient	Sig.
Explanation of the blocks	2,4	.429
Bars	- 4,2	.202
Non-directive	-.6	.899
Green questions	8.8*	.011

Focusing on strengths	2.8	.613
Taking and discussing pictures	3.5	.549

Note. * = significant at p<0.05. All other elements were not significant at p<.1.

Graph 3

Adherence per element through time, according to therapists



Explorative analysis

Finally, an additional analysis was done to explore the difference between the average adherence score of online (Yucel Home method) sessions (n=10) and face-to-face sessions (n=28) based only on the first session of a therapist-client dyad. This was done by conducting an independent samples *t*-test. The difference in average adherence between online sessions (M=67, SD=11) and for face-to-face (M=65, SD=12) was not significant in an independent samples *t*-test (t(35) = -.520, p= .607).

Discussion

In this study therapist adherence to the Yucel (Home) method was explored. Assessed was how adherent therapists are, and if their level of adherence changes over time. It was assessed if there was difference in the six core elements of adherence, and if the average adherence per core element changes over time. To answer these questions, the data from two different questionnaires were analyzed by means of *t*-tests, ANOVA analyses and regression analyses.

The first research question of this study concerned the level of adherence of therapists using the Yucel method and the Yucel Home method. It was found that the total level adherence of the therapists was 69% (SD=11). A score of 61% or higher can be considered adherent. Client's evaluation of therapist adherence was on an average score of 84% (SD=17). The difference between therapist and client's average adherence score was significant. The results concerning the second research question of this study 'Is there difference in adherence between the six core elements?' indicated that there was a difference in adherence between the six core elements of the method. Based on therapist data only, the average adherence scores per element varied from 44% ('Green questions) to 94% ('Bars'). Results concerning the third research question; 'Is there a change in the average adherence over time?' showed that based on therapist data only, the level of adherence of the therapist did not change significantly over time. The results concerning the fourth research question of this study 'Is there a difference in adherence between the six core elements of the method over time?' showed that of all the elements, there was only significant change in 'Green questions' over time. Finally, in an additional analysis concerning adherence between online (Yucel Home method) and the face-to-face version it was shown that adherence did not differ between versions.

Interpretation

An average adherence score of 69% can be considered adherent. This means that in the first session of the Yucel (Home) method, the therapists were following the treatment protocol as supposed to. A score of 69% is a promising outcome. As mentioned in the introduction adherence to the protocol is an important first step in gaining more insight into the workings of the protocol; it can indicate that the protocol is apparent to follow and therapists do not need more guidance. The information derived from adherence research can be used as feedback for therapist supervision sessions.

In this study a choice was made to base the average adherence score on the therapists' answers and to use the client data only as a source of additional information. This choice was made because the therapist questionnaire had more questions, and the therapists filled in the questionnaire after every session, whilst the clients received a call to answer adherence questions every other session. Furthermore, some research indicates that therapists are a reliable source of information when it comes to self-assessment of adherence. Although not in all studies this outcome is found (Herschell et al.,2020). The data showed that in all analyses there was a discrepancy between the average adherence score of the therapists and those of the clients. There are multiple explanations for this discrepancy. As mentioned in the introduction, in previous research it was found that clients may overestimate the level of adherence of the therapists (Herschell et al.,2020). This might have been the case in this study as well. Another explanation could be that because some of the participants were perhaps people with a mild intellectual disability (MID) or borderline intelligence (BI), it is possibly that some of them had difficulties answering the questions. In this study there was no data collected about the intellectual level of the clients involved but many clients of Koraal function on the level of MID or BI. The client questionnaire was fairly simple designed but not completely tailored to the needs of clients with MID or BI. According to Jen-Yi et al. (2015) people with MID or BI often have challenges with judgement or acquiescence, the tendency to say yes despite the question. People with MID or BI are not always able to adequately retrieve information from their memory and might interpret questions wrong. Another possibility is that the therapist underestimates their own level of adherence, although the literature shows that therapists more prone to either overestimating themselves or have a correct view of their level of adherence, in concordance with the expert rater (Herschell et al., 2020). Therapist underestimating their level of adherence has to my knowledge not yet been found in research. Last, there is also the possibility that both the therapists and the clients

overestimated the level of adherence and that perhaps an independent rater would have concluded on a lower average level of adherence.

Differences in the level of adherence between the six core elements of the method were found. In the Yucel method, 'Explanation of the blocks' and 'Focusing on strengths' are considered important core elements of the method, and thus were weighted double. According to the therapists, the average adherence of 'Explanation of the blocks' was 72% and 'Focusing on strengths' showed an average score of 68%. Both scores can be considered adherent. These findings suggest that the therapists do not need extra training to apply these two elements. It suggests that the therapists are proficient enough in explaining the blocks and in directing the conversation towards the client' strengths. The same goes for the element 'Bars' (94%) and 'Non-directiveness' (72%). However, considering asking green questions (44%) and taking and discussing pictures (54%), therapists were less adherent and might need extra training in order to be more adherent. A reason why element 'Green questions' was rated on a lower level of adherence could be that it is a less straightforward part of the method. Whereas for example, the elements 'Explanation of the blocks' and 'Bars' are more straightforward elements, with exact guidelines what and how to explain. Applying 'Green questions' is a more open aspect and there are many different ways the therapist can ask questions to make the client more aware of their positive traits and resources. Another explanation for the low 'Green questions' adherence scores is that the element or the construct 'Green questions' is measured by three questions and two of those questions are rather specific. Whereas in the protocol manual there are many ways of asking of 'Green questions' mentioned. Therefore, it might be that the therapist did ask other 'Green questions' but just not the three questions from the questionnaire. It could also be that because asking these types of questions requires a different attitude of the therapist than what they might be normally used to. In 'Green questions' the focus is on resources, skills and positive traits. Whereas in normal therapy sessions, therapists might be inclined to talk about sorrows and problems.

As for the element 'Taking and discussing pictures', the beneath average adherence score could be due to the fact that two out of the three questions were not relevant for the first session ('we discussed the picture of the last session' and 'we made a comparison between the previous picture and the current picture'). Although these questions were not relevant for the first session, they were asked regardless and answers to these questions might obscure the average adherence outcome for this element.

Knowing the difference in adherence between elements yields valuable information

about applying the Yucel method. By breaking down the method in elements, supervisors can effectively consult the therapists in what aspects some extra attention is needed. This would both enhance their level of adherence and their level of competence. In Multi System Therapy this has shown to be beneficial and improved the level of adherence among MST therapists (Schoenwald et al., 2000).

Contrary to expectations based on research on adherence, the level of adherence did not change over time. Therapist'adherence didn't fluctuate over sessions. As mentioned earlier, it is more common for therapists' level of adherence to increase in the course of the treatment (Lange et al., 2019). That the average level of adherence stayed at the same level in this research can be considered a positive result. Meaning that the therapists are adherent throughout all sessions, which in turn could have a positive effect on treatment outcomes. Research on the relationship between treatment outcomes and adherence shows contradictory findings, and adherence is just one variable of many that influence treatment outcome (Perepletchikova, 2011). However, some findings suggest that there is a positive link between higher levels of adherence and better treatment outcomes (Lange et al., 2019). But as treatment outcomes were not part of this research project for the Yucel (Home) method this remains inconclusive. It should also be noted that out of the twenty-two therapist-client dyads, just eight dyads were based on multiple sessions. Most dyads were based on one session. The limited data of adherence over time could explain why the level of adherence did not increase. Perhaps when more sessions are analysed, an increase would become apparent. Thus, because there is limited data of adherence over time, one should be cautious to draw conclusions about the progression of adherence over time. The results showed that based on the therapist data, the change in adherence between the six core elements of the method over time was only significant for the element 'Green questions', the average adherence increased throughout the sessions. A reason for this could be that the because the therapists need to answer the questionnaire after each session, they are reminded of the importance of the different elements of the Yucel method. The questionnaires can function as a reminder of the rationale of the method. Therapists are reminded of the importance of asking about how the client used to solve their problems in the past or how the client could make a burden block smaller. Nonetheless, the average adherence score of 'Green questions' remained beneath average, and it can be concluded that this element needs to get more attention during training and supervision. From all twenty-two dyads, only one client-therapist dyad was based on five sessions. The information concerning datapoint five provides should thus be interpretated with caution. There was less data from online sessions than expected. A reason for this could

be that therapists were hesitant to conduct online sessions as this is a new development due to circumstances (Covid-19), and therapists might not feel confident to apply therapy online. Or it could also be that therapists just prefer face-to-face contact and opted for a real-life session whenever possible, as research on the attitudes of therapists towards online therapy indicates (Topooco et al., 2017). On average, the level of adherence during the online sessions was 67% (±11) did not differ significantly for the average adherence of face-to-face sessions, 65% (±12), This is supported by the literature on online psychotherapy (Simpson, 2009). This suggests that in training professionals to work with the Yucel method, there is no need to pay special attention to adherence when using the home version of the method. But because of the limited data this conclusion should be considered with care.

Scientific relevance

This study, being the first to explore the level of adherence of the therapists using the Yucel (Home) method, gives insight into the usefulness of the protocol. Since the method is growing in popularity, and evidence of its effectiveness is only anecdotal until now, this study is leading the way for future research on the Yucel (Home) method. In this study a first step in understanding therapists' level of adherence has been made. The average adherence score was considered adherent. A second step would be exploring if there is a positive correlation between adherence and outcome. Recommendations for future research will be outlined below. Although the data on online sessions was limited, the results do indicate that there is no need for special adherence attention for online sessions which is hopeful considering the current ongoing pandemic (Covid-19), and therapy sessions continue to be partly online.

Limitations and suggestions for future research

This study had both strengths and weaknesses. First, that both the therapist and the client participated as raters of therapist adherence in this study can be considered a strength. Research shows that having multiple perspectives increases inter-observer consistency. Besides having multiple informants, two different questionnaires were used to assess the level of adherence of the therapist. This increases measurement validity (Bryman, 2008). A second strength of this study was that according to the standards of Schoenwald et al. (2000, pp.88), the research instruments were relatively simple and inexpensive, which is considered favorable. Future research should determine whether this is actually the case.

A weakness of this study is that the level of therapist competence was not measured.

Most authors on treatment integrity stress the importance of competence in relation to adherence (Waltz et al., 1993). Although it was safeguarded by means of training and supervision, it was not measured in this study. That competence was not measured in this study could obscure the results of this study. Reports from Yucel therapists who were not competent enough could have influenced the level of the adherence scores, either the average scores or per element, especially the more complex elements. Future research on adherence could include an independent observer who both observes the adherence and the level of competence of the therapist. A second weakness lies in the adherence measurement used in this study. One of the problems with the concept adherence is, is that there is no consensus on how to exactly measure it (Southam-Gerow & McLeod, 2013; Lange et al., 2019). As outlined in the introduction, there are a several guidelines on how to develop an adherence measurement instrument. The instrument developed for this study does not fully comply with the guidelines as outlined by Waltz et al. (1993). Therefore, it adds to the list of different types of adherence measurement instruments. Furthermore, since this study is the first to use this adherence questionnaire and it has been specifically developed for the Yucel (Home) method, the question remains if the results can be generalized. A third weakness is that there is no standardization of the questionnaires available yet. It is therefore difficult to determine if the level of adherence is considerably high or low compared to others. Furthermore, as mentioned before, the questionnaires are not validated. This means that it is unknown if the questionnaires are valid and reliable. The last weakness is that the sample of this study was small, therefore the results are less conclusive and should be interpretated with caution.

A few recommendations for future research can be made. According to Waltz et al. (1993) adherence should be the first topic of research, when starting to comprehend the working of a particular protocol or method. Including competence in adherence / treatment integrity research would be favorable, since the nuances of conveying a protocol go beyond following the protocol step by step. Especially when it comes to asking ‘Green questions’, a certain level of competence in the Yucel (Home) method would be beneficial.

Another recommendation in future research on adherence is to include an expert rater. The expert rater could evaluate video or audio recordings of the therapy sessions and provide a different and perhaps more objective insight of the level of adherence of the therapist. According to Herschell et al. (2020) some studies indicate that expert raters are more objective than the therapist and the client, which might result in a different average adherence score. Once the level of treatment integrity is fully established, the relationship between adherence and treatment outcome can then be studied. It would be interesting to see if a

higher level of adherence also means a better treatment outcome, or that, as some research indicates a medium level of adherence relates to a better treatment outcome (Barber et al., 2006).

Another recommendation is regarding the adherence measurement instrument. In future research it might be beneficial to take a closer look at the element ´Green questions´. It should be measured by more than three questions, or different types of questions, to make sure the concept ´Green questions´ is measured accurately.

Another interesting angle for future research is to explore the Yucel Home method versus the face-to-face version, to research the experience of the therapists and clients using the method online versus face-to-face.

The last recommendation would be that additional research is needed to draw stronger conclusions, and that future research includes more client-therapist dyads with multiple sessions, so adherence in time can be studied more thoroughly.

Conclusion

Despite its limitations, this study yields new information about therapist adherence to the Yucel (Home) method. In this study it was found that therapists were adherent to the protocol, according to both the therapists and the clients. The clients rated the therapists' adherence score consistently higher than the therapists rated themselves. The level of adherence did not change significantly over time. Furthermore, there was a difference found in adherence between the six core elements of the method; the elements 'Green questions' and 'Taking and discussing pictures' were not adherent based on the therapists' answers. The elements 'Explanation of the blocks', 'Bars', 'Focusing on strengths' and 'Non-directive' were considered adherent. There was no change found in adherence between the six core elements of the method over time, except for the element 'Green questions'. Significant differences in adherence scores between online sessions (Yucel Home method) and regular face-to-face sessions were not found. These results are promising but further research is necessary to understand more in depth about therapist adherence to the Yucel (Home) method.

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Appendix 1. Client questionnaire

Cliënt vragenlijst

Uitleg over de blokken

1. Heeft de ondersteuner uitgelegd wat de lange balken betekenen? ja = 100 nee= 0
2. Heeft de ondersteuner uitgelegd wat de blokken in de vorm van een T betekenen? Ja = 100 nee=0
3. Heeft de ondersteuner uitgelegd wat de rechthoekige blokken betekenen? = ja 100 nee=0
4. Heeft de ondersteuner ook iets verteld over de kleuren van de blokken? = ja 100 nee=0
5. Wie koos de blokken waarmee gebouwd werd? Ik= 100 ondersteuner = 0 samen = 0
6. Wie koos hoe de blokken werden neergezet? Ik= 100 ondersteuner = 0 samen = 0

Balken

1. Wie koos met welke lange balk gewerkt zou worden? Ik= 100 ondersteuner = 0 samen = 0

Foto's maken en bespreken

1. Is er een foto gemaakt van de laatste opstelling? ja= 100, nee = 0, weet niet= ?
2. Is de foto van de laatste opstelling is besproken? ja= 100, nee = 0, weet niet= ?

3. Adviseerde de ondersteuner om tussen de afspraken door naar de foto van de laatste opstelling te kijken? Ik= 100, nee = 0, weet niet= ?

Niet sturend zijn

1. Wie koos welke woorden op de blokken werden geschreven? Ik= 100 ondersteuner = 0 samen = 50
2. Wie bedacht oplossingen voor problemen? Ik= 100 ondersteuner = 0 samen = 50

Groene vragen

1. Wie koos hoe de lasten blokken kleiner gemaakt konden worden? Ik= 100 ondersteuner = 0 samen = 50

2. Begrijp je de ondersteuner altijd ja= 100 nee= 0 weet niet = ?

Krachten

1. Heeft de ondersteuner vragen gesteld over dingen die mij helpen? Ik= 100, nee = 0, weet niet= ?

Appendix 2. Therapist questionnaire

Therapeuten vragenlijst

Uitleg over de blokken

1. Heeft u tijdens de eerste sessie de betekenis van de volgende blokken uitgelegd? - De lange balken ja = 100 nee= 0
2. Heeft u tijdens de eerste sessie de betekenis van de volgende blokken uitgelegd? - De T-vormige blokken ja = 100 nee= 0
3. Heeft u tijdens de eerste sessie de betekenis van de volgende blokken uitgelegd? - De rechthoekige blokken ja = 100 nee=0
4. Heeft u tijdens de eerste sessie de betekenis van de volgende blokken uitgelegd? - De kleuren van de blokken ja = 100 nee=0
5. Ik liet de client zelf kiezen welke blokken hij/zij wilde gebruiken vaak= 100, nooit=0 soms=0
6. Ik gaf suggestief waar de cliënt een blok neer kon zetten vaak= 100, nooit=0 soms=0
7. We hebben een blok uit de opstelling gehaald en op tafel gelegd om erover te praten vaak= 100, nooit=0 soms=0

Balken

1. Ik liet de cliënt zelf kiezen welke balk hij/ zij wilde gebruiken vaak= 100, nooit=0 soms=0
2. Mijn cliënt vond alle vier de balken erg op elkaar lijken vaak= 0, nooit=100 soms=50
3. Mijn cliënt had een goede redenatie voor het kiezen van een bepaalde balk vaak= 100, nooit=0 soms=50

Niet sturend zijn

4. Ik gaf suggesties welke krachten/ lasten mijn cliënt op de blokken kon schrijven vaak= 100, nooit=0 soms=50
5. Ik gaf adviezen hoe mijn cliënt zijn problemen op kon lossen vaak= 100, nooit=0 soms=50
6. Ik liet mijn cliënt zelf oplossingen bedenken door het stellen van vragen vaak= 100, nooit=0 soms=50

Groene vragen

1. Ik heb gevraagd hoe de cliënt een lasten blok kleiner zou kunnen maken vaak= 100, nooit=0 soms=100
2. Ik heb gevraagd hoe mijn cliënt zijn problemen vroeger oploste vaak= 100, nooit=0 soms=100
3. Ik stelde vragen die mijn cliënt niet begreep vaak= 0, nooit=100 soms=50

Focus op krachten

1. Ik stelde vragen over de familie/ vrienden van mijn cliënt vaak= 100, nooit=0 soms=100
2. Ik stelde vragen om erachter te komen elke dingen mijn cliënt blij/ rustig maken vaak= 100, nooit=0 soms=0
3. Ik heb benadrukt dat mijn steun tijdelijk is vaak= 100, nooit=0 soms=100

Foto's maken en bespreken

1. Na de sessie is er een foto gemaakt van de opstelling vaak= 100, nooit=0 soms=0
2. De foto van de vorige sessie is niet besproken vaak= 100, nooit=0 soms=0
3. We hebben een vergelijking gemaakt tussen de opstelling van de huidige sessie en de foto van de vorige keer vaak= 100, nooit=0 soms=0